STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
LONG-TERM CARE ADVISORY SUBCOMMITTEE

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-and-
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MEETING OF THE
LONG-TERM CARE ADVISORY SUBCOMMITTEE

Meeting of the Subcommittee was held by videoconference on Wednesday, June 17, 2015, scheduled for 9:30 A.M.

MEMBERS PRESENT IN CHICAGO:
Michael Waxman, Chairman
Judy Amiano
William Casper
Cecilia Credille
John Florina
Charles Foley
Alan Gaffner
Carolyn Handler
Steven Lavenda
Patricia O'Dea Evans
David Raikes (Phone)

MEMBERS PRESENT IN SPRINGFIELD:
William Bell, Vice-Chairman
Paul Corpstein
Kelly Cunningham
Timothy Phillipee

CHICAGO STAFF:
Jeannie Mitchell
Juan Morado
Claire Burman
Courtney Avery
Ann Guild

SPRINGFIELD STAFF:
Mike Constantino
Nelson Agbodo
George Roate
Mike Mitchell

GUESTS:
Pat Comstock (Phone)
John Kniery
Kirk Riva
Amanda Ginther (Phone)

AGENDA

CALL TO ORDER
1. Roll Call
2. Approval of Agenda
3. Approval of March 24, 2015, Meeting Transcript
4. UPDATE: Legislative Initiatives - Courtney Avery/Jeannie Mitchell/Ann Guild
5. LTC Bed Need Formula - Nelson Agbodo
"White Paper"
Impact of Bed Need Formula on Buy/Sell Program
6. Ad Hoc Group - Buy/Sell/Transfer "Points of Consensus" - Judy Amiano
7. Other Business
8. Next Meeting
9. Adjournment

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(Meeting began at 9:47 A.M.)

CHAIRMAN WAXMAN: We have called roll. Do we have a quorum?
COURT REPORTER: Who is speaking?
CHAIRMAN WAXMAN: I'm Chair, Mike Waxman.
Okay. I need a motion to approve the agenda.
MR. GAFFNER: So moved. Alan Gaffner.
CHAIRMAN WAXMAN: Need a second.
MR. FOLEY: Second. Charles Foley.
CHAIRMAN WAXMAN: All in favor?
(Ayes heard.)
CHAIRMAN WAXMAN: Any opposed?
(No response.)
CHAIRMAN WAXMAN: I need a motion to approve the March 24, 2015, transcripts from our last meeting.
MS. HANDLER: So moved. Carolyn Handler.
CHAIRMAN WAXMAN: Have a motion. Need a second.

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MR. CASPER: Second. Bill Casper.
CHAIRMAN WAXMAN: Have a motion. Have a second.
All in favor?
(Ayes heard.)
CHAIRMAN WAXMAN: Any opposed?
(No response.)
CHAIRMAN WAXMAN: Okay. Next on the agenda is the legislative update initiatives and all rumors, and, Courtney, are you doing this by committee?
MS. AVERY: Yeah.
CHAIRMAN WAXMAN: Go head.
MS. AVERY: Well, you know, the last meeting we had we looked at House Bill 3510 and came to some compromise with the originator of the bill, Donna Ginther and Pat Comstock, and I always get their --
COURT REPORTER: I'm sorry. I didn't get the names.
MS. AVERY: Donna Ginther and Pat Comstock -- of HCCI? -- of HCCI and have reached some compromises and figured out a way to live with 3510.

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So I don't know if people had a chance to review it or not or if there were questions regarding it, but the most significant change is, of course, the composition to the subcommittee. And one of the agreements is that we will now note -- and we'll get to that sometime today -- how you will be listed as a member of the subcommittee, your agency, and then who you represent as far as the three associations so that there's clarification. Because one of their concerns was that they didn't have enough representation on the subcommittees.
The other issue was the term limit for the chair, which we agreed to -- I think it was -- was it two or three?
UNIDENTIFIED: Three.
MS. AVERY: -- three years and to look at the bed need formula, which we're going to start on that today.
Oh, and then also remove the voting rights of the ex officio members of the subcommittee.
I think that was the gist of it. Did

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I miss anything, Ann or Jeannie?
MS. GUILD: Just some deadlines.
MS. AVERY: Oh, yeah.
MS. GUILD: Having to make recommendations to the Board on January 1, 2016, and annually thereafter.
COURT REPORTER: I'm sorry. Who's speaking?
MS. GUILD: Sorry. Ann Guild.
And then the bed need formula recommendation by January 1, 2017.
MS. MITCHELL: And then one thing with the --
Jeannie Mitchell.
One thing with the membership of the associations. They want equal number of members between associations. There's no -- it doesn't define what that looks like. It just says that it has to be equal numbers, and we have time to get there. So the law isn't demanding that we get there immediately when it comes in effect.
COURT REPORTER: When it comes to what?
MS. MITCHELL: In effect.

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MS. AVERY: In effect. When the law becomes effective.
UNIDENTIFIED: Did it pass? Yes, I'm dumb.
MS. AVERY: Yeah, it passed out of both houses -- 35 --
This is Courtney. Sorry.
It passed out of both houses and waiting on signature of the Governor.
CHAIRMAN WAXMAN: Referring to the Board as the Motherboard?
COURT REPORTER: I don't who's talking again. I'm sorry.
UNIDENTIFIED: Mike Waxman.
COURT REPORTER: Okay. I'm assuming the Board is the Motherboard, is that what you said?
CHAIRMAN WAXMAN: That's what I said.
COURT REPORTER: Thank you.
MS. COURTNEY: Any other questions from Springfield regarding House Bill 3510?
MS. AMIANO: This Judy Amiano.
Courtney, what is the removal of the voting rights of the ex officio? Who were the ex

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officio that were voting?
MS. AVERY: The departments -- aging, public health, and DHS.
UNIDENTIFIED: And HFS as well.
MS. AVERY: HFS. Yes.
MS. AMIANO: Thanks. So it's down to how many voting members?
MS. AVERY: 15.
UNIDENTIFIED: The law doesn't spell out how many voting members we can have; so --
MS. AVERY: But we have --
This is Courtney.
We have 19 and removing those --
UNIDENTIFIED: Right. Right.
MS. AVERY: Okay.
Any other questions?
CHAIRMAN WAXMAN: This is Mike.
So, again, we have to do our bylaws over again to specify the number for a quorum? The number for all that good stuff?
MR. MORADO: This is Juan Morado.
Yes. We -- Jeannie, myself, and Claire -- had a short discussion about this. We're going to -- we anticipate that the bill

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will be signed. It has support from both the Board and from some of the other stakeholders that were involved. We're going to make changes to the bylaws, make sure they're in accordance with the newly signed bill when that happens. We hope to bring that to you at the next subcommittee meeting; so -- absolutely.
MS. AVERY: And I have to say that it was watered down a lot. As you know, we had a long discussion about 3510 at the last meeting, and there was some good compromise once we met. The compromises were made between Board staff, representing you all, and the feedback that was given and HCCI.
CHAIRMAN WAXMAN: That's it?
MS. AVERY: That's it.
CHAIRMAN WAXMAN: I was looking for a two-hour song and dance.
MS. AVERY: You're about to get one.
CHAIRMAN WAXMAN: Okay. We're going to skip 5.
Okay. Item 5, Nelson -- where is Nelson?
MR. AGBODO: I'm here.

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MS. AVERY: He was hiding.
CHAIRMAN WAXMAN: Okay. Nelson, we've allocated five hours for you; so go for it.
MR. AGBODO: Oh, thank you.
Well, I would like to go over this material that was sent to everybody. So I would like to use a few minute to go quickly over the material and at the end -- and the questions. And Mike Mitchell also is here to help me with the questions.
So on page 2, I provided some abbreviation and definitions that have been used in this material.
So, first, I would like to thank Mike Mitchell for providing data and ideas for analyzing the data; and Bill Dart and Claire for advising on the methodology and document layouts; Courtney Avery, Mike Constantino, George Roate, Jeannie Mitchell for proofreading the document.
So this presentation will focus on three main subjects. The first one is the bed need methodology. So I would like to provide more detail on the component of the methodology, the computational steps, and, you know, from

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there I will take departmental comment on the white paper.

Then we will talk about the bed need projection for state, health service area, and the health planning areas.

So doing that, we will actually compare projected patient days to actual patient days from 2000 to 2010. And then we also take a look to the actual use rates from 2003 to 2013.

Then we will actually realize that the main issue -- it's about how we allocate beds between health planning areas. So I will give some idea for improving the allocation. So we will review the health planning area use rate assumptions, and I will give some notes on the data quality.

So let's start on bed need methodology. So the bed need method that I'm presenting here is what we have from the Code, the Administrative Code, pertaining to the long-term care. And if you look at the methodology, okay, it has three components: the mathematical formula, the data, and assumptions that I actually call adjustment rules.

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So the mathematical formula just says bed need estimates or projection, okay, equal use rate times at-risk population estimates or projection.

And I would like quickly to make a different between estimate and projection. Estimate consider all the past population, size and the structure, whereas projection is concerned with future population.

So we are in 2015. Anything we want to do going from 2015 down, maybe, 2000 or 2013 will be considered as estimates. But if we're giving population value from 2016 and up will be projection. Just so you can understand the rest of the presentation.

So the mathematical formula is not predictive. It's just estimate. So it meaning that -- it mean that, you know, projection -- the data we -- or the value we project might be different from the actual value because it's not predictive.

So the data that we use in the formula: We have patient days by age group, population estimate by age group, and licensed

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beds. Actually, we also use population projection by age group.

And the patient day are based on resident counts for the whole calendar year, the entire calendar year. It's not one-day data. It's for the whole calendar year. And the population estimate are based on a set of assumptions. We are not going to cover that yet because it's a part of demographic work. And the licensed beds are exact numbers that we can verify with IDPH.

The assumptions, okay, include projected use rates. So the assumption on that is that it will remain the same for each year of projection period. And also we have the 90 percent occupancy rate. I think everybody's familiar with that. And we also have 60 to 160 percent of health service area use rates range. So what that says is the planning area use rate have to be between, you know, 60 and 160 to be considered as it's calculated, but if it's less than 60 percent, then the 60 percent of the area service -- of the health service area will be used. When it's more than 160 percent, then they

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will come back and use 1.6 times the area -- the health service area use rates. But we'll come back to that because I have a numerical example to explain that.

So the bed need methodology step-by-step computation. So here actually provide the mathematical formulation. I'm not going to go into that, but the first thing we do when we compute -- the first thing we do when we compute the bed needs is to calculate the bed use rates -- the base use -- I'm sorry -- the base use rates. So the base use rates equal the base patient days divided by base population. So the -- actually, the base year is set by the most recent population estimate year. For example, the new inventory will have as -- 2013 as the base year.

Then on page 7, after we have the base use rates, we now calculate the health planning area projected use rates. By doing that, we use the first adjustment, okay, rules. That's, for each age group, the minimum and the maximum planning area use rates are 60 percent and 160 percent of the area service -- or the

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health service area experienced use rates.
What that mean is, like I was explaining, if you calculate the planning -- the base use rate for health planning area and it's less than 0.6 times the health service area, then you -- actually, the projected use rate for the planning area will be 0.6 times the health service area use rates. But if that base use rate for the planning area it's more than 1.6 times the health service area, then you actually use 1.6 times the health service area use rates. If the base use rate for the health planning area is between 0.6 times the health service area use rate and 1.6 times the health service area use rates, then you consider the base use rate that you calculate for the health planning area.
So by doing that, there is some gain and loss of beds.
Then the third step -- at the third step we calculate the projected patient days. The projected patient days equal projected use rates times projected population -- or projected population for the health planning area.
Then once we have that, we sum the

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projected patient days by age group. We sum them up to get the total projected patient days for the health service area.
Then we move to calculate the projected average daily census. The projected daily census is actually the total project patient days divide by number of days in the year. Usually it's a 365 day.
And at the end we actually divide the projected average daily census --
Are they listening?
MS. AVERY: Yeah. We're just trying to hook in a call. So continue.
MR. AGBODO: Oh, okay. Thank you.
MS. AVERY: We're fine.
Mr. AGBODO: So we divide the project average daily census by 0.90 --
MS. AVERY: One second, Nelson. Sorry.
(Off the record.)
MS. AVERY: Thank you.
MR. AGBODO: Okay. Can you hear me now?
MS. AVERY: Yeah. You're fine.

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MR. AGBODO: Okay. All right. So actually we were on how we calculate the projected patient days. So the health service area project number of needs -- of bed needs -- it's obtained by dividing the projected average daily census by 0.9. That's when we use, actually, the 90 percent occupation -- occupancy assumption.
So by doing that, actually, we are increasing the bed needs by 10 percent. So it's just similar to multiplying the daily census by 1.1, you know, or 110 percent. And I actually provided the mathematical formulation in the bottom for you guys to look at it.
So at the end we obtain a number of excess or number of additional -- additional need beds by subtracting the number of existing licensed bed from the number of projected bed needs.
So by doing all this, we actually use two assumptions. I want to wrap up on that. The first one is the 60 percent or 160 percent rule allocation assumption. By doing that, we don't follow strictly the historical use rates. So,

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you know, that's one of the assumption, anyway.
So the next assumption is the 90 percent occupation rate that ensure 10 percent extra beds.
So that's, you know, the step-by-step computation, and to make it little bit easier to understand, I provide here a numerical illustration by using the health service area number 7 that include Cook County. So this is the map we have on page 10, and the data I use is from the 2013 inventory.
So first thing is to have the input data. Like I said, we have -- we have to use 2010 patient days, 2010 population, and 2015 projections for population. And we have this data by age group. The age group are zero to 64, 65 to 74, and 75 plus. So here in this example the base year is 2010, and we are projecting in 2013 for five years. So we are projection for 2015.
So the first thing to compute, like I said, is the base use rates, and I provided that calculation here in this second table. So we have to obtain the base use rate for the health

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service area and the health planning area.
Then we go to the third table where we use the 60 to 160 percent assumption to calculate the minimum and the maximum use rates. So here we use the health service area use -- base use rates, and we multiply by 0.6 to get the minimum and 1.6 to get the maximum for each age group.
Then the next table we use the minimum and maximum to have the projected use rate for the health planning area. So, for example, zero to 64 age group, the beds use rate was 0.0969 and is not in between 0.456 and 1.2124. So since it's not in that range, the projected use rates for the health planning area will be 0.6 times the health service area use rates, which was 0.4546.
So same thing applied to the age group 65 to 74. But 75 and plus, the use rate we calculated for the health planning area, which is 21.2341 -- it's in between 3.4833 and 35.9555. So we left that bed use rate as it is for the projected use rates. So finally we obtain the projected use rate for the -- you know, for each

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age group.
Then the next step will be to obtain the projected patient days. So we will multiply the projected use rates for the health planning area by the projected population for each age group. So, like I said, we are projecting for 2015. Then, you know, that is the data we use for that. So you will see the result we obtain there.
Then step five. We will get the health planning area projected bed needs by multiplying the projected patient days -- no -- dividing the projected patient day by 0.9. So we get the results right there, and the bed needed for the area finally -- it's 446. So we get that by subtracting the number of existing licensed bed from the projected bed needs.
I hope that make this easier to understand.
So looking all this and the white paper that have been submitted to us for review, I would like to make some comments.
So the white paper clearly said that the bed need formula -- it's mathematically

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sound, which I agree to because, you know, in demography, epidemiology, you know, all this scientific area, when you want to project, you use the use rates and you apply to the at-risk population. It's a standard practice. So nothing wrong about that.
Then the paper actually finds some issue mainly with the application of the formula and the input data. So the first one, inconsistency in the projected bed needs numbers, my comment is, when you have the same formula and different data, you should have different results. So the result cannot be the same for every year. So for -- you know, I don't really understand the inconsistency that the paper talk about.
And, actually, HFSRB staff does not make any adjustment to the final bed needs. So we -- what we obtain by applying the whole methodology, that's what we publish.
And one of the issue from -- in the white paper is the reliability of input data. So about the population data, the census data is the only gold standard for population data

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comparison. If you get population data from different vendors, you want to compare them or average them to use that in the formula, you are not going to get anything better. But if you -- you know, a data set -- population data set has to be compared -- has to compare to the census data.
So the best option for us is to have a control over the projection methodology and computation, and operate adjustment to minimize bias and variances of the projection model on an ongoing basis. So that's what we are going for, for now.
The patient days are collected for the entire calendar year and undergo a thorough data validation that I actually do. That's part of my job.
And also the reimbursement data set that we use, the HFS data quarterly census, to improve the bed need estimate. For me, you know, this census, actually, it have a different objective. So this data is collected for the Medicaid reimbursement purpose. And I use the data and compute a use rate and compare to our

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use rate. There's no big difference. I think the difference is, like, 1 percent. So they are very close.

So the licensed beds, like I said, is exact numbers that we can verify with IDPH. So that one should not suffer of any deficiency. So the timeline --

MS. AVERY: Nelson?

MS. AGBODO: Yes.

MS. AVERY: Judy wants to ask you a question real quick.

MS. AMIANO: Just a quick question. Under the population data heading, your second bullet point is "The best option is to have a control of population projections methodology and computation." Could you elaborate on what that comment means?

MR. AGBODO: Yes. So if we are to buy data from vendors, we are assuming that their methodology is the best; right? We -- we are buying the data with, you know, all the consequences, I mean, if it -- you know. But if we have the control over the computation, we compute our own projection, we know the

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methodology that we are using, and if we evaluate in the future the projection against census and we find issue, we can go back to the material and see where, you know, the problem is coming from, and we can actually make some adjustments.

Because, actually, like I presented, the methodology has also assumptions. If your assumptions does not stay strong over a certain period of time, you want to go back and review them based on new data -- like, you know, migration data, birth and death data -- and to readjust your projection and get better results.

But a vendor will not give you their methodology. They will not give you that. And so, since they don't give you the methodology, you don't know exactly how they are computing the data for you, and there's no way you can compare that methodology to census bureau methodology, which is the gold standard in the demography fields.

So today we have computed our own projections. That has been posted on the website, the Board website.

CHAIRMAN WAXMAN: Judy, does this

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answer your question?

MS. AMIANO: I'm not sure. I'm just trying to understand. So you're recommending, Nelson, that -- you're not making a recommendation for a change. You're saying the current methodology is the gold standard methodology. Is that a correct statement?

MR. AGBODO: Well, the recommendation I'm making is we should not buy population data from vendors because we don't know how they compute them. We should produce our own -- we should produce our own projections because we have -- we have the competency to do that.

MR. KNIERY: You have done that.

MR. AGBODO: And we have done it. And the methodology we have used has been evaluated against census data, and it has shown that it's the best -- I mean, not the best, but it's a good methodology we are using because the gap between our projection -- it was in 2000, actually. I was not here, but, you know, the state demographer did the work. And the 2000 projection compared to the 2000 census has a very small gap. It mean that the methodology that we

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have been using -- it's a good methodology.

I don't know if that --

MS. AMIANO: Thank you. That helped to clarify.

MR. AGBODO: Okay.

MS. AMIANO: That was good. Thank you.

CHAIRMAN WAXMAN: Nelson, hold on one second please.

To the court reporter, would you please indicate that Pat O'Dea has joined us in Chicago?

COURT REPORTER: Yes, I will.

MR. RAIKES: Chairman Waxman, this is David Raikes, subcommittee member, R-a-i-k-e-s.

CHAIRMAN WAXMAN: Oh, thank you. Welcome.

MR. RAIKES: Thank you.

MS. COMSTOCK: And Pat Comstock with HCCI is here.

MR. KNIERY: Since you're at a stopping point, if I may.

This is John Kniery.

This demographic that you have put

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together and is now on the Board's website is something new that had not been used in the last -- or the most current inventory. This is going to be used for going forward on the next inventory; correct?

MR. AGBODO: Yes.

MR. KNIERY: Okay. Just for clarification.

UNIDENTIFIED: This is the same methodology.

MS. AVERY: This is -- yeah, it's the same. Nothing's changing.

MR. KNIERY: Same methodology. I'm talking about the demographics --

MS. AVERY: Yeah, nothing's changing.

MR. KNIERY: -- the demographics to be used --

MS. AVERY: Okay.

MR. AGBODO: Right.

MR. KNIERY: -- will be different.

MS. AVERY: Well, those changed, yes.

MR. AGBODO: Right. It will change.

MS. AVERY: That changes.

MS. AGBODO: We'll be using --

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MR. KNIERY: But we use a different source in 20 -- in the current?

MR. AGBODO: Right. Yes. I heard that was data bought from Nielsen?

MR. KNIERY: Nielsen, yeah.

UNIDENTIFIED: So we are using a different source --

UNIDENTIFIED: Yeah.

UNIDENTIFIED: -- for population?

MR. GAFFNER: Nelson, Alan Gaffner with a question.

If I understood you correctly, you are indicating that the population data used in the formula originates with the department rather than being purchased from any of a number of vendors; is that correct?

MR. AGBODO: That's correct.

MR. GAFFNER: And how do you work to those population datas whether they be at the ten-year census mark or in the years consecutively in between?

MR. AGBODO: So our projection is five-year projection because I change the projection periods from ten years to five years.

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And when we project, it's for -- when we project the bed need, it's for five years, but every two years we will have to review the inventory and then, you know, the base -- base year population data as well. So it will be every two years.

MR. GAFFNER: Every two years the raw -- as I would call it, the raw population data is re-based or re-evaluated for accuracy?

MR. AGBODO: Yes. It will be evaluated for accuracy, especially when we have new birth and death publication because those are the ingredient to estimate the population. Once you have the estimate, you can project for five years.

MR. GAFFNER: But when the raw population data, which I would call the floor, is either re-calibrated or assessed for accuracy, what yardstick is used if it isn't Nielsen or another vendor? I'm just trying to determine how the state has the accuracy of these population numbers without use of some third-party vendors.

MR. AGBODO: Right. In this process, we might not provide you or need a third party because actually the data that we need to do the

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estimate -- we can have them. We -- you know, they are the migration data, birth data and census data, and death data. So IDPH publish those data. I mean, especially the birth and death data. From what I recall, they publish that every -- I mean, right now I think they already publish 2012, and we have 2013 ready. That's what we are going to use for the next inventory. So as they publish those data, we have more accurate data to re-adjust the projection. So will not need anybody else to do this work.

MR. DART: And if I could add, Nelson -- this is Bill Dart. I'm not going to put myself on the camera because I've got the remote.

But we have a state demographer, Mohammed Shahidullah, and Dr. Shahidullah works closely with Nelson on the methodology using the census figures as base numbers and using the vital records input, births and deaths and migration data, to build out this model.

MR. GAFFNER: And, Bill, this is Alan again.

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That census data that is used -- again, it's origin is that federal website, or where does that first bucket of data originate?

MR. AGBODO: Right. The census data come from Census Bureau. So federal --

MR. GAFFNER: Okay.

MR. AGBODO: -- yes, agency, yes.

MR. GAFFNER: All right. Thank you both.

MR. AGBODO: Thank you.

So I'll continue with page 16. So the timeliness of inventory -- there was a comment about that. Actually, the inventories and population projections has been -- the timeline has been set by the Planning Act. They have Planning Act. So I have them on page 16. You can take a look.

So, basically, every two years we will have to have a new inventory and every five years -- we will have to project for every five years.

Maybe -- right now we have -- so we had a five-year inventory in 2013. That is due in 2015 for revision. So every two years. And

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then in 2015, where we are right now, we need another five-year inventory. That will be due in 2017 for revision and so on. So that how the timeline is set.

So quick comment on data on bed need projection. So this is basically to answer the question how the methodology has performed in predicting the future. So by doing this, we actually comparing the projected numbers to the actual numbers.

So I have some concepts here that I would like to define first. So the data source that we have used in this analysis comes from the annual survey database that HFSRB does every year. And the variables are projected patient days. In the inventory it's called planned patient days. So there are patient day calculated for projection year using the bed need methodology, and the actual patient days are patient days reported to HFSRB by the long-term care facilities through the annual surveys.

So what we call here bias will be the difference between the projected value of the bed need methodology and the actual value reported by

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the long-term care facilities.

And the variance will be the variability of the methodology projection for giving data points.

And I can come back to those concepts if they are not clear.

So the use rate -- it's is number of patient days projected or used, depending on where -- you know, what kind of data we using, divided by total possible number of patient days. For Table 2 in this document, the total possible number of patient days is calculated by multiplying the total licensed beds by 365. So for Figures 7 to 11, this value was obtained by multiplying each age group population by 365.

So the software -- you know, we use Excel, SPSS, and ArcGIS 11 to produce the map.

So now the graphs. So the first graph is the state's projected versus actual patient days. So we compare both for 2000, 2002, 2005, 2008, and 2010.

So the green bar here represents the actual patient days, and the red is the projected patient days. So you can see that 2000, 2002 the

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actual was higher than the projected. But from 2005 to 2010, the projected were higher than actual patient days.

So the conclusion from here is that the project patient day remain higher than the actual patient day from 2005, and the assumption that use rates will remain the same over the projection period is optimistic because projecting more, and that the bed need methodology is projecting enough bed for the industry, if I may say that. I will even say that it's overprojecting for projecting beds.

So the difference -- the difference you see between the projected and the actual patient days in term of beds from 2000 to 2010 -- it's around 17,350 beds. That's the overprojection for the beds.

So this trend -- it's also observed at health service area level. So here 1, you know, on the axis -- on the axis, 1 to 11 are the health service areas. So you can see that health service area 6, 7 -- I think those are the one that has Chicago and, you know, Cook County, you know, the big counties. So that -- in those

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areas, you have very big numbers, and from 2005, the projected bed numbers were higher than the actual numbers. So at --

MS. AMIANO: Nelson?

MR. AGBODO: Yes.

MS. AMIANO: This is Judy Amiano.

Quick question. I'm back on Slide 18. Is it -- I just want to make sure the numbers are right. Are there really almost 29 million patient days in 2010?

MR. AGBODO: Yes. Yeah. Those are the numbers that we -- we got from the database, and I think they are right.

MR. CASPER: Nelson, this is Bill Casper. Can I ask another question back on Figure 2 just so I can be sure I'm -- well, I'm not sure but to test whether I'm understanding this.

Can you explain the reason why the projected need goes down from 2008 to 2010? Is that because the actual use gets worked into the formula over that period of time?

In other words, you show, based on population numbers, it goes up while utilization

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is going done, but all of the sudden in 2010, the projected need goes down. Is that because the prior period utilization is actually factored into the formula?

MR. AGBODO: So -- yeah. I can't say yes or no because I have not evaluated that. You know, the projected values can be affected by the use rates and also by the population growth. So I don't know -- you know, I haven't evaluated it to see what's the impact, you know, from each --

MR. CASPER: But in general, population is growing and use rate is going down. So it's probably the use rate that's affecting the projection --

MR. AGBODO: Okay.

MR. CASPER: -- if you need to take a guess; right?

MR. AGBODO: You know, I don't know for sure.

MR. KNIERY: This is John Kniery.

If I may, you had a couple different things going on during this time also, just to know the history. There was a base year -- I think early on in 2000 there was a base year

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population of X, and the projected five years wasn't five years. It was still X. As a result of that, you had legislation that brought in a ten-year projection which -- which wasn't valid either. I think five years is a good projection. I think we've talked with a lot of the staff, and I think that was the concurrence. And so I think you see some of that.

So I think you have both -- you may have both items, Bill, coming in. You have a lower use rate that's affecting it, and you're bringing it back with a five-year projection versus a ten-year projection. I think we're getting back on track.

MR. AGBODO: Yeah. So from --

CHAIRMAN WAXMAN: Nelson? This is Mike.

If the -- the projections are based on licensed beds; correct?

MR. AGBODO: No. Projections --

CHAIRMAN WAXMAN: Your projections are based on licensed beds?

MR. AGBODO: No.

UNIDENTIFIED: Partially.

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MR. AGBODO: No, they are not based on licensed beds. They are based on, I'll say -- when we say use rates, it's actually the occupied beds, I will say, but not directly because what we do, we actually get the number of patient days for the whole year and we divide by the population to get the use rates for when we are calculating bed use rates. So it has to do more with occupied bed than the licensed beds.

CHAIRMAN WAXMAN: Because my concern is that we all know that so many of the licensed beds are out of -- out of use; right?

MR. AGBODO: Yes.

CHAIRMAN WAXMAN: That's common knowledge. So my fear was that, if you're using licensed beds, there is no way to reach the projection because those beds don't exist in reality.

MR. AGBODO: Yes. That's right.

MS. CREDILLE: This is Cece.

Slide 9 -- doesn't Slide 9 refer to a formula related to number of existing beds? So is that licensed beds?

MR. AGBODO: Slide 9.

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MS. HANDLER: This is patient -- this is project -- what they're really showing here is patient days. They're projecting patient days -- Carolyn Handler.

They're projecting -- Slide 18, they're showing projected patient days versus the state's actual patient days, and that formula is actually, I think, described the page before that, Cece, on page 8.

MS. CREDILLE: Yeah, but I'm referring to Michael's --

This is Cece Credille again.

-- Michael's question about whether or not licensed beds is in the formula. It looks like it is on Slide 9, and it's stated in the bed need methodology on page 5.

MR. AGBODO: Okay. Let me rephrase this. The denominator of the base use rates has the licensed bed because we actually multiply the license -- I mean, the licensed bed by 365 to get the patient days that, you know, all the licensed bed can --

UNIDENTIFIED: Maximum.

MR. AGBODO: -- the maximum licensed

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bed that make -- still make available to the market -- I mean, to the industry. So, yes, in the denominator we have the licensed beds.

On the numerical -- in the numerical we actually have what has been actually used. So yes to Mike's statement.

CHAIRMAN WAXMAN: Thank you, Nelson.

MR. AGBODO: You are welcome.

Mike, do you add something to that?

MR. MITCHELL: This is Mike Mitchell. I'm with IDPH staff.

The projections that are done do not incorporate the licensed bed numbers. It's strictly based on the utilization numbers. The patient days and the populations are how -- are what are projected forward. Once we get the projected number of beds needed, we compare that to the current licensed numbers to see if there's is a need or an excess. But the -- but the current number of licensed beds do not affect the projection.

CHAIRMAN WAXMAN: Okay. Thank you.

MR. PHILLIPPE: This is Tim Phillippe. Can I ask a practical question? I'm

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not a mathematician.

So to go back to Mike's earlier question about bed use, so if I look at the year, on page 18, 2010, and what we would have to have, really, is -- and assuming, say, 5 percent of the beds are out of service. Take a number. That would mean we have to actually predict a greater need to account for the fact that some beds are not available. Is that possible or not going forward?

Like, if I took 2010 on the chart here and they were both equal -- okay? -- if they were both equal, then what I'm assuming is everything worked in the formula perfectly, and you're using a 90 percent target; right?

MR. AGBODO: Yes.

MR. PHILLIPPE: Then that would mean that, if every bed was in service, then all The -- on average, it would be running 90 percent census across the state.

UNIDENTIFIED: Right.

MR. MITCHELL: Yeah.

MR. PHILLIPPE: However, say, if 5 percent of the beds are not in service, then,

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practically speaking, we're running -- you're actually running 95 percent of the beds that are set up. And so to account for that, we either have to use a lower census target, 90 percent, or do something to -- to grow the need. Does that make sense? Is that what's happening?

MR. KNIERY: Mike, this is John Kniery.

You're never -- with the way it's set up, if it was a perfect world, you would always see the projected as 10 percent higher. You'd never see them below.

So I think to show a need -- I don't think it's -- you know, that's the objective. I think the objective is to project the appropriate patient days from the most current base year forward over a population. So I guess I'm not following -- I'm not quite following your -- what you're trying to --

MR. PHILLIPPE: So actually -- this is Tim Phillippe again.

What I'm saying is just what you said. You said, if you used the 90 percent formula, then the projection's going to have to

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be more; right?
MR. KNIERY: It's all -- yeah.
MR. PHILLIPPE: Because you're accounting for that 10 percent. Okay. However, if the true beds available are not what we have here, they're actually -- beds in service are 5 percent smaller, then, really, to get -- it affects the availability; right? So the true census actually out there, in terms of set-up beds, would be running a much higher number. That's what I'm trying to get to.
So, anyway, that's okay. Maybe I don't understand it well enough to even ask a question about it.
MR. CORPSTEIN: Paul Corpstein.
So what you're saying is that the beds that are not in service but may be on the license -- so they have a hundred beds on their license, but they're only using 80 of them. So we would count only 85 of those beds. Those 15 would just be taken off, and that would increase the amount of -- that would increase the occupancy. So basing it on, like, a 10 percent over what their actual occupancy is and not on

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their actual number of beds that they have.
MR. PHILLIPPE: Right. So I'm --
This is Tim.
I'm not proposing how we should answer the question. But what I'm doing is going back to Mike's comment that it really assumes the beds are all in service the way we're using it, and they're not.
So there could be a need in a community even though the formula wouldn't show a need because there's lot of beds out of service.
MR. CORPSTEIN: Right. And the beds out of service is where they get the 72 or 75 percent based on HFS data and stuff that I determine type of stuff. So that's why we're at the 75 instead of 90 because they're carrying extra beds.
MR. PHILLIPPE: Okay.
MR. CORPSTEIN: And -- I mean, whether they're in use or not. So whether they're set up or --
MR. KNIERY: That's almost a separate issue, Mike, isn't it? Mike Mitchell? That's almost a separate issue than the bed need

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calculation itself. We're almost talking two different things with set-up beds because the calculation -- and, hopefully, if they have a lower use rate, that's going to project forward, if it's done consistently. That will be, I guess, processed if things keep -- you know, are updated consistently every two years, hopefully sooner than that, but --
MR. AGBODO: So I would like to come back to the formula, and how we actually calculate the use rates. Like Mike said, we actually use the previous use rates as the base -- I mean, the base year use rates, and then with 60 to 160 percent rules, we adjust that use rate to have the projected use rates, and we multiply the population projection to -- with that number to get our denominator for, you know, this comparison.
So by doing that -- and I'm correcting my statement again. By doing that we don't use the licensed beds. So -- so if we are in the perfect world where the actual and the projected match, we will still have 10 percent -- 10 percent of beds that -- actually 10 percent of

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the bed that the 90 percent occupancy assumption gives will be used then, which will not be, you know, possible because that can only happen if there's, you know, overuse -- overuse of the facility capacity.
So we will always project more than the actual use unless something, you know, happen that was not, you know, seen before. So just to rectify what I said, you know, about the formula.
So if you may allow, I will continue with the presentation. On page 20, here -- we actually provide here the actual patient days use rates at the state level from 2003 to 2013. So if you see the last line, Illinois, on average, we'll say 78 percent of -- this based on licensed bed, by the way. So different from the graphic that I -- you know, we already comment.
So 78 percent of licensed beds are being used. That's what this table are telling us at a state level, an average. You know, on average, 78 percent of licensed beds are being used.
And from 2003 to 2013, the use rate of licensed bed has increased about 4 percent --

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has been decreased. I'm sorry. There's a decrease of 4 percent. And if you go into the HSAs, HSA 11 has the highest decrease, 13 percent, and HSA 9, in contrast, shows an increase of 4.7 percent.

On page 21, we are now analyzing the patient days data at health planning area. So before it was at state level, then HSA level, and this one is at health planning area level.

So 2008. We know that we have 95 health planning areas in this state. So out of 95 percent -- out of 95 HPAs, 59 in 2010 -- 2000, I'm sorry. 59 did not meet their projected numbers. They are below their projected number, and only 36 were over the projected number.

So if you go down to 2008, 87 were below the projected number, and eight -- only eight were over the projected number.

So actually provide a graph -- I mean, a map -- the state map on that figure to show how this situation is distributed in the states. So the red areas use more beds -- patient days that was projected for -- than what was projected for them, and the gray area were

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below the number that was projected for them. So this clearly shows allocation issues between the areas, the health planning areas.

So the total number we project for the state -- it's good enough, but when we come down to distributing that total number between the health planning area, some area get more than it needs, some area get less than it needs. And I think that's the main issue that we need to address here.

And for that I think we will need to optimizing the bed need allocation between the health planning area. So the first thing I'm targeting is the 60 to 160 percent rules because that's the rule -- or the assumption that distribute the beds among the health planning area.

So the first questions I would like to investigate is, is there a correlation between the use rates changes and being below projected patient days numbers?

The next one is, is there a correlation between use rate changes and being below projected patient days number with respect

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to each age group?

And the third one is, is there a correlation between having the average calculated use rates higher than or lower than the selected use rates -- that when we use the 60 to 160 percent rule -- and below -- and being below projected patient days?

So one way to do that is to increase the flexibility of the methodology, but if you do that, you have to --

Are you on mute?

MR. DART: Yeah, they muted.

UNIDENTIFIED: Still hear you, though.

MR. AGBODO: They can hear me?

UNIDENTIFIED: Yes. We can still hear you, but we're on mute.

MR. AGBODO: Okay. So to do that, to make the methodology flexible, okay, and, you know, have a better allocations of beds between the health planning area, we have three, I will say, proposal.

The first one is to use a fixed ratio. I think that was from a Bill Bell

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communication.

And another one that I was thinking about is to use the historical use rates. So the 60 to 160 percent rules may not be applied.

And the third one is to find allocation factor through a modeling. So, you know, put everything back to -- to zero and try to re-evaluate parameters. That will allow for a better allocation of bed between the health planning area.

So this graph on page 24 show, you know, the total -- the total error will be, you know, the difference between the projected and the actual; right? So if you -- if we consider more variable in the methodology -- okay? Let's say that we want to introduce patient origin variable. This will make the methodology more complex, and the error due to bias will increase. So it mean that, you know, the projected value compared to the actual value will be so different. I mean, the gap will be big. And so the bias will increase. However, the variance will -- will decrease, meaning that if you project for two different year, the difference

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between those two year may not be that big, but when you compare the projected to the actual value, the difference might be bigger. So that's the trade off, between, you know, bias and variance.

So having -- having the control over the population projection methodology like I suggested will help to monitor this issue much better. If you are buying that data from a vendor, they are not going to work on this for you on yearly basis unless you have more money for them.

So on page 25, we present here the health planning areas' average projected and actual use rates for 2010, and the green line is the actual use rates. The red is the projected use rates. So the use rates -- as you can see, the use rates vary -- vary widely. There's, you know, big spikes, you know, and up and downs. So the average actual use rates range between 26.4 beds per thousand population and 1.2 bed by per thousand population. So, on average, projected use rates is very close to the bed use rate, and this is the total numbers at the state level.

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Okay.

We can see some significant deviancies between -- for some health planning area. For example, I think this is Ford and -- Ford. You have -- the actual is way beyond the projected. But, you know, at the state level it looks like the formula is doing very well. Actually, we have seen that is overprojection number of bed for the state. The formula is -- so it's doing very well at the state level.

So on page 26, we have projected and actual use rates for age group zero to 64. Here you can see that the significant -- there's a significant gap between projected and actual use rates. Again, the use rate here -- the projected is the red, and the actual is green; right? So the line -- you know, the linear estimate shows that the actual is higher than projected, and this, you know, for this age group is kind of strange, but that's what the data showed.

And on page 27, you have -- actually, the projected is higher than the actual. So this is age group -- age group 65 to 74.

And the last one, 75 and plus, you

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also have the same thing. The projected is higher than the actual.

So the next graph on page 29 compares the projected use rates, actual use rates with a fixed use rates of 50 beds per thousand population. So the black line, straight line, is the fixed use rate. So the variance between fixed use rates and the actual use rate is huge. You can see that. You know, just one line cannot summarize all those up and downs. So would be very strange to use a fixed use rate for the State of Illinois.

So I'm going to wrap it up quickly to, you know, summarize the findings. So by doing all this analysis we have found that the bed need methodology projects number of patient days -- therefore, number of beds -- higher than the number actually used at the state level.

Allocation of total projected patient days between health planning area is not optimal. So some area have more than they need, and other have less than they need. And that for me is the main issue. So the issue is not about the total beds projected for the state, but it's how we

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allocate the projected bed between the health planning areas.

And the total patient days' absorption is decreasing. We have seen that.

And projected use rates trend higher than actual use rates for age groups 65-74 and 75 plus, except zero to 64 where we have seen that the actual was higher than the projected.

So higher projected use rates and population growth -- like I say, I have not evaluated this, but those two explain higher projected patient days compared to the actual patient days.

So use rates for each age group vary significantly between health planning areas, okay, and planning areas' use rates may not be well projected by a fixed ratio or a linear model.

The variability observed between projected and actual use rates may be related to the assumption built into the methodology and especially the 60 to 160 percent adjustment rule.

So a quick note on the data quality. Like I said, there's -- there are no good or bad

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population estimate until census numbers comes out for the same year. For example, 2010 census and 2010 projection can be compared and see the gap. That's how you know if your methodology is doing a good job or not. So the census counts are the gold standard for comparison when it come to population data.

We will be using our own population projection and estimates. The methodology -- which is called administrative record because it use administrative records -- was tested against census counts and proven reliable for producing Illinois county population projection. So the mean average error -- the mean average error found between the census count and the projection for 2010 was only 1.92. I mean, if the mean average is zero, that's the best. That mean perfect match. But 1.92 is actually very low. So that study was published by the state demographer, Mohammed Shahidulla and Mark Flotow in 2005. I have the publication available for anybody who want to take a look.

So the number of licensed beds are exact number. So that number is not questionable

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because can be -- that can be verified with IDPH.

The patient days are based on an entire calendar year admission. So trend analysis of this data does not show any abnormality.

From 2012, data collected through HFSRB annual survey undergo a thorough data validation process where we actually follow up on every issue and document them.

So in recommendation, I recommend that, you know, predictive modeling to redefine use rate allocation factor be conducted, and by doing that, we will have to see -- to analyze the variability between the actual use rate and the base use rate. Also analyze the variability between predicted and actual patient day due to population data. Like I said, 2000 data was evaluated. So we now have 2010. We can do the same evaluation and maybe go back and do 1990. So those are the census years, and we can do the same analysis to see if the methodology we are using -- it's giving us less error.

So the estimate -- the maximum and the minimum value for health planning area use

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rates has to be re-evaluated. I'm talking about the 60 and 160 percent.

And, also, we might introduce patient origin variable into the methodology. Like I said, that may increase the bias. So, you know, the actual and projected number might -- you know, the different might increase between those two values, but if we have a control over the methodology, we can have adjustment for that.

So in conclusion, the analysis of the components of the bed need methodology shows that there are no significant deficiency in the structure of the formula. So that formula is a standard practice. So I don't really see any change to the formula.

Input data are less likely to be biased -- like, the population data, the patient days for the whole year, and the -- the licensed beds are published numbers, and, you know, we'll have more control over that. So there's no -- for me there's no big question about the data.

And assump -- it's the assumptions that might be outdated and need to be re-evaluated. So we don't know how they come up

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with the 90 percent, 60 percent, 160 percent rules; so -- but we know that the 90 percent occupancy rates ensure 10 percent extra beds for unpredicted circumstances. 60 to 160 percent adjustment rule is to ensure equilibrated repartition of beds within each health service area. So these objectives should be re-evaluated using collected data over the last 40 years of the existence of the CON program.

So I would like to thank you for your attention. Now, like I said, Mike and I can have the questions and try to answer them.

MR. FOLEY: This is Charles Foley.

Nelson, first of all, I think we need to thank you immensely for this detailed study. Obviously, you put a lot of time, thought, and effort into the process, and for that I personally wish to thank you.

MR. AGBODO: I appreciate that.

MR. FOLEY: I agree with probably 90 percent of what you said today. I will not go over the 10 percent because I don't think it's important at this point in time because I believe that you are still working on it, and hopefully

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some of these issues that you have identified can in fact/will in fact be worked out in the future.

So, once again, I just want to thank you for your -- for your time and efforts between you and all of those others in the department that assisted you in this process.

MR. AGBODO: Thank you.

MS. AVERY: What room are you guys in? I need to send a sign-in sheet up to you and Bonnie can't find you.

MR. DART: We're in the conference room on the fourth floor.

UNIDENTIFIED: 535 Jefferson.

MR. DART: Fourth floor, 535.

MS. AVERY: Okay. All right. Go ahead with questions. Thank you.

MS. O'DEA EVANS: This is Pat O'Dea Evans.

I also -- Nelson and also the whole team that helped you with this, I think this is crucial information for us to have, and I think, you know, it's too bad we're just getting this now because I think we had a lot of questions, and I think this is something that helps clarify

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quite a bit of debate that we had over many issues that was obviously unnecessary debate.

But I think we need to, you know, look at how we deal with the fact that there are obviously areas that have need and other -- you know, that, you know, are underserved, and I don't think we've really addressed that.

CHAIRMAN WAXMAN: Mr. Foley.

MR. FOLEY: Nelson, I guess some other areas of concerns that I would like to ask is, obviously, a lot of this information, in terms of bed need and the methodology itself, we are, in fact -- and this is -- you know, our problem is that we are showing a lot of empty beds. What are we doing in terms of looking at the total picture in long-term care? It looks like we just got part of the problem here, and that is the issue just with long-term care facilities.

But what about those patient days of care that are being rendered and could be classified as nursing -- when I say "nursing," I mean, like, at the ICF level -- in our assisted living facilities and supported living

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facilities? And we even also have people residing at home getting nursing care. All of these factors affect, you know, the bed need. Are we doing anything at all to try to incorporate home health care, assisted living, supported living into our methodology in the future?

MR. AGBODO: From my opinion, I will say, if we include those parameters, the bed need projection will go down because.

UNIDENTIFIED: A lot.

MR. AGBODO: Yes. Yes. Because then the pattern will have to follow the use rate which is going down. And I don't know if we have data actually on those item to incorporate that in the formula. I don't know if Mike had to add something to that. I don't know if we have data for that. But, you know, like I said, the use rates show that patient are going somewhere else. If we want to incorporate that in the formula, the projections -- the bed need projection will go down as well.

CHAIRMAN WAXMAN: This is Mike Waxman.

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Again, I think that issue -- again, as Pat alluded to, this information should have been out -- you know, would have been helpful out earlier. However, the same issue that Chuck is raising, we've been talking about the day we started this committee -- is that we all are aware that there are many assisted living residents that really truly need skilled care and they're not -- they're not getting it for whatever reason.

However, unless and until this committee or the Motherboard is able to suggest that assisted living and supported living become part of our database, we're going to be trying to figure out that issue for -- from now until Kingdom come.

MR. FOLEY: Of course, the problem with that, Mr. Chairman --

I'm sorry. This is Charles Foley.

The problem with that is that legislatively they're not in our control.

CHAIRMAN WAXMAN: Correct. That's what --

MR. FOLEY: And that's our biggest

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problem. So unless we get them under control by changing legislation so that we can include some of that data into our calculation so that we could have a truer total picture --

CHAIRMAN WAXMAN: Totally agree with you.

MR. FOLEY: -- you know, because now we just got part of the problem.

CHAIRMAN WAXMAN: I think we all agree with you, and we've all said that in several --

MR. FOLEY: And I guess it would be interesting to know -- Mr. Chairman, I think it would be interesting to know what the Motherboard themselves -- what they are thinking about in terms of long-term care. I mean, we've heard comments and statements out there that why have this bed need methodology when the Board is still approving projects anyway, especially in the areas where there's not a bed need.

And, you know, I think in -- probably in defense of the Board, one has to realize that each and every single project that this planning Board receives is different. They are not the

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same, and that is why we have nine different minds, so to speak, sitting at the table making these very delicate, you know, decisions.

So even though they may, in fact, be approving projects where there's not a bed need, it would be interesting to also know, again, their thinking. What do they see as the future in long-term care? We are acting as advisors, so to speak, to the Motherboard, but I think it would be interesting to know if we could -- gosh, it would be great if this whole community could sit down, you know, after a Board meeting sometime and sit and address the Board members just to see where they're coming from, what they're thinking, and what have you. That might help us, you know, to do our future planning as well.

CHAIRMAN WAXMAN: My understanding was that Dale Galassie was supposed to be on the phone.

MS. AVERY: Yeah, but he has a special day today.

CHAIRMAN WAXMAN: This is a special day. We're meeting.

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MS. AVERY: This is Courtney. Let me -- go ahead, Mr. Phillippe.

CHAIRMAN WAXMAN: Tim, go ahead.

MR. PHILLIPPE: Yeah, this is Tim Phillippe.

I just want to -- sorry to go back a little bit, but it was hard to get in.

But to kind of dispute what Mike, our chairman, said on one thing. I don't know if -- if we think about public policy nationally, I don't think most people would agree that there's a lot of people in assisted living who should be in skilled nursing beds. I think the concept of where care should be provided -- whether it's at home, assisted living, supported living, clearly, or in long-term care facilities -- I think the public policy from a higher level is changing and is certainly changing even with managed care's part of that coming into the state and also nationally.

So there's a feeling by others that people can -- who had needs that would have been cared for in a long-term care facility ten years

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ago can get appropriate care today through a Medicaid waiver program at home, in assisted living, supported living. Now, we could all debate what we think is correct -- where a person should be based on their need -- but it seems to me it's very obvious that the population, citizens at a whole, believe that more of them can be taken care of adequately outside of a long-term care facility. And there's certain federal policymakers who agree with that, and they are pushing that trend.

And it's affecting our use -- and it's affecting our use, and it's going to continue to affect the use as more and more options are available for people outside of a facility setting.

CHAIRMAN WAXMAN: I don't disagree with you at all, and I think that we all are aware of the trend to care for people in the least restrictive and home environment.

I guess what I respond to is when I walk into assisted living and I see those cases that clearly need skilled nursing and they're not getting it. I guess it's the exception that

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bothers me more than anything else.
But I agree with your philosophy, and the philosophy that you are talking about is absolutely true. And, of course, there's a cost attached to being in a least restrictive environment also.
So I agree with you, but what bothers me more than anything else is to walk through assisted living buildings and look at people who -- being non-clinical, but I've been in this business for a lot of years -- know that skilled services probably would help them.
Pat.
MS. O'DEA EVANS: I do want to -- I do want to remind us that, you know, both assisted living and the supported living are licensed health care entities, and they have specific requirements that prevent them from being used as skilled sites. I mean, there's specific requirements in our license. So, you know, we are -- there is oversight there.
You know, we -- we are going to have a trend where there's less days in skilled care. Medicare care is pushing that. Payers are

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pushing that. Network -- complete networks are pushing that. So I think it's -- you know, I don't think assisted living or supported living is going away, and it's likely to grow.
I think it is a little frustrating that, you know, we don't really have a handle on what that book of business per se is and how it relates to our mission here. I think that's the -- that's really kind of the frustration piece -- is that there's not a good integration of everybody.
CHAIRMAN WAXMAN: I agree with you.
John, I saw your hand and never got back to you.
MR. FLORINA: Well, I don't want to reiterate what's been covered. I had a question before Mr. Foley had spoke.
But, first off, thank you, Nelson, for the detailed analysis of the information so we better understand the factors that go into the whole process here.
But the obvious question I had is you showed data of the population growing for those over age 60. At the same time, you showed the

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utilization rates for nursing home care -- because that's all we're reviewing -- is nursing home beds -- nursing home beds declining. The actual occupancy data shows that there's less days of care being provided than what's being projected.
So as accurate as the methodology is designed, the data that we're putting into it makes a difference. And if we are going to help regulate the number of beds that are being provided, it's hard to do that if we exclude those factors -- meaning non-nursing home options -- that are being utilized to provide services for long-term care, but at the same time using the same system, whether it's the formula or the inputs, to arrive at our -- how many beds are needed.
So if we continue down this trail, it appears that we're constantly hitting our heads against the wall about saying we have excess beds everywhere, but we're not in any way acknowledging how that's being created by eliminating or leaving outside of the picture these non-nursing home placements.

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So whether it's assisted living or home care or whatever else it may be, we're going to have this discrepancy in our use versus our projections until we somehow include it in the process, whether it's a change to the data that you use, what percentages that you use. That's what I was getting to, and it was already addressed, but hopefully it gave a little more clarification.
CHAIRMAN WAXMAN: Alan.
MR. GAFFNER: Thank you, Mr. Chairman.
I believe what was said -- and I can't remember whose phrase, but it's the important one relative to the impact that assisted living and supported living have had -- "appropriate setting for care."
And as I talk to my colleagues, they report continual clinical cases where AL and SL residents find themselves in the acute care hospital setting or admitted directly to the long-term care setting because they were not properly addressed in the AL/SL setting.
I agree that the consumer model is

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going to continue to want AL and SL. They're not going away. Nor should they. But this term is used -- and let's all admit it -- in both locations. Our colleagues -- and it's an appropriate term. They are unlicensed nursing homes. They are licensed for AL and SL, but they are not licensed for skilled care, and that level of care is increasing in inappropriate settings. And it costs the federal government when they're readmitted to an acute care setting. And I believe that we should keep that on our radar screen as we address these issues. Many of us offer all levels of that care. But let's not kid ourselves that, when they remain in those settings instead of going to skilled, that it impacts this occupancy.

And then I have a quick question for Nelson, and I want to also add my thanks for the work, and thanks, Nelson, also, and I appreciate the agenda being set up where you could walk through it page by page because it answered a number of questions I had.

I go back to what Tim and John were saying. I still believe that that 90 percent

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occupancy level does skew the overprojection and the underutilization. I don't know what the magic number is. Probably somewhere between 70, 75, and maybe 85 percent. And that would still need to allow for a cushion, but that 90 percent level -- and help me if I'm -- if I'm commingling here, Nelson, but I believe, if that number was adjusted, that it would bring the projection graph and the use graph more closely in line. And I say that because I believe that is not accurately reflecting the need that exists in certain planning areas where beds could be considered approved by the Planning Board.

MR. AGBODO: Yeah. My comment to that would be at the state level the use rates, when you consider the licensed bed, okay, 78 percent, and the 90 percent should be compared to that. If the use rate at the state level goes close to 90 percent, then there's no more, you know, gap there. So that -- you know, there the 90 percent might be re-evaluated. So for me at this stage, there's no need to change the 90 percent. That me, you know.

But now, if you go down to the health

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planning area -- I mean, you go in health service area and you look at the health planning areas, I think the allocation between the health planning area is not effective, and that is because of the 60 to 160 percent rules. That one need to be re-evaluated.

And like this -- the map -- the state map shows, in the Chicago area, they are using more patient days than has been projected for them. So by changing the 60 to 160 percent assumption to something that I don't know yet, I'm hoping to see beds migrating from the gray area to those red areas, and that will solve the problem. And that can even solve the 90 percent problem that we might see at health planning area. So, you know, that's what I think. I don't know if Mike, who manipulate actually the methodology, can add something to that.

CHAIRMAN WAXMAN: Judy.

MS. AMIANO: This is Judy Amiano.

So, Nelson, I too would like to thank you. I think the document and your walk-through of it did a good job of bringing everyone to a common platform. So that is appreciated.

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I guess I would just like to have on the record that there's been a couple of statements in the room of "We all can agree" about care levels and those kinds of things. I think when we're all speaking we need to speak from our own place and not speak for the group because there's been things that I would disagree with that were put in the frame of "We would all agree" with this statement. So I would just like that on the record.

And then I think that we should also have at the beginning of every meeting -- and perhaps we can go back to that place right now -- what is the purpose of the subcommittee, what were we charged to do, because we tend to stray down a lot of variant paths, and we really need to stay laser focused on what our objective is and what boundaries we were given by the Board as a subcommittee of the Board. And so maybe a place for us to start -- and maybe Claire or Courtney could take us there now -- is what is it this group is supposed to be focusing on and what is our, you know, desired outcome, and, you know, let's stay on that path of how can we continue to

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migrate towards that end.
MS. AVERY: This is Courtney.
Basically, when the subcommittee was created with -- I think it was Senate Bill 1905 -- it was charged with this group coming together to give recommendations for rule changes, trends in long-term care. So it's kind of vague. And then later there was legislation that was introduced for the bed sell and exchange program. So it's been kind of all over the place.
The first goal was accomplished with the changes in the rules that were presented a couple years ago and then now in the Administrative Code. That piece of legislation came later. So it's kind of evolving.
MS. AMIANO: And the bed --
MS. AVERY: It's just legislative.
MS. AMIANO: The bed need formula -- the statute specifically says that that needs -- you need to be making a recommendation by January 1, 2017.
MS. AVERY: The new one.
MS. AMIANO: The new one.

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MS. AVERY: And then there was one other clarification that was in there that dealt with the correction of the inventory, and I don't want to use the wrong language, but it was to kind of look at used and unused beds. There was a piece in the Health Planning Act that also covers that, but that's more on the Board side. And because of lack of resources, we really don't have an accurate count in facilities what are the unused beds.
CHAIRMAN WAXMAN: Judy, I think the word "trends" is what opens everything up, you know, into our discussions because, again, it -- what I remember early on is that we're supposed to make sure that the rules and the regs and policies kind of follow the trends of what's going on in the industry, and I think that's kind of how we get down into some things that don't seem like they're mainstream all the time.
MS. AVERY: This is Courtney.
There was also a piece in Senate Bill 1905 that made sure that long-term care wasn't being held -- I don't want to say accountable -- wasn't looked upon the same as hospital-based

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long-term care facilities and acute care. So that's why we created that separate set of rules just for the long-term care industry.
But it's always evolving and -- as you know, long term.
CHAIRMAN WAXMAN: Judy, does that help you, or are you still feeling like we're --
MS. AMIANO: Well, you know, from a personal feeling, we've been at this for a number of years, and I guess I'm just trying to figure out what -- what's the specific problem we're trying to solve and how are we making steps towards getting there, and so that we can feel like we're, you know, moving this forward as opposed to the inertia that we've had for some period of time. So, you know, now that, you know, 3510 is there and there's specific dates, I want to be mindful that we have an agenda that moves us to a place.
MS. AVERY: And this is Courtney again.
One of the stumbling blocks that I can say that we've all had as staff and frustration is that our inventory is not

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accurate, and it's not accurate because of the self-reporting data. And I've said time and time again, until we know what are the unused beds that are out there, we probably won't -- we'll struggle trying to accomplish a lot of these goals.
MS. AMIANO: So my biggest question for Nelson after this presentation was, if the problem isn't the formula, then why does everyone have such heartburn? I mean, what are the ideas? You know, I mean, because this is very logical. It makes a whole lot of sense, and so -- but if this -- this has been what people have pointed their quivers at for a long time -- that the bed need formula is what's the problem. And if we're hearing, after a thorough analysis, that's not the problem, then what are some thoughts around that?
MS. AVERY: And I'll ask that the industry address this back because we have a variety. We have larger, smaller, independent at the table, and I think one of the -- in my sidebar conversations with providers is that it's not a showing need, but their communities are

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dictating that they need beds, but our inventory doesn't show a need, which stops them from building new facilities or adding beds outside of the 10-10 rule.

MS. AMIANO: Yeah. I mean, I will tell you from my -- or my company's experience is, you know, if you're running any kind of Medicare volume, it now takes two-and-a-half patients -- two-and-a-half admissions what used to be one admission because the length of stay has reduced so dramatically. So what used to be, you know, 25, 35, 40 days is 15 to 18 days today. And that's in that 2008 to 2000 -- or 2010 to 2015 timeline. So you're seeing a lot more throughput. You might be seeing actually more residents than you were back then, but their lengths of stay are much, much shorter.

So, you know, it is a very rapidly evolving system in terms of the bed utilization, at least in my -- I see you guy shaking your heads too -- you know, so from a provider perspective. So, you know, on any given day you always have beds because they're in, they're out, they're in, they're out.

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So, you know, the folks who are in the long-term care beds, you know, some of those folks have -- you know, because of the number of the initiatives across the state to get people to their least restrictive environment and to have been successful -- which "Hooray!" for those individuals who are able to be served in less restrictive environments -- and, you know, the level of community support programs that have been implemented over the years to address some of the needs.

So, you know, I guess I'm just trying to wrap my head around where -- what are we trying to accomplish, you know, in a very succinct manner. I don't know if I'm feeling alone or not, but I --

CHAIRMAN WAXMAN: I don't think you're alone. I think those of us, like -- you know, who have been here from day one, sitting in traffic for two-and-a-half hours, driving down here thinking "Why I am doing this? I've been doing this for two-and-a-half years, and what's going to accomplish today be any different?"

But I think we are making process. I

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think the group has changed. There's been some new additions that are a lot more focused than some of the original players in the community. I think we have cleaned up some of the things that originally were done. We have created a new application solely for nursing homes and separated them from the hospital world. I think the conversations have become a lot more focused and intelligent because of the people who are in the room. That's my feeling.

But, again, I think we've struggled with trying to get to a finished product because of so many things that we can't -- that we recognize we need and we can't get to. And I think that's part of the frustration.

Mr. Foley.

MR. FOLEY: I think that is our continuing problem.

I'm sorry. This is Charles Foley.

Our continuing problem is the number of empty beds that we have in the state, and as Courtney indicated, how do we identify, you know, those unused beds? What do we do with them? And that's what affects the bed need. That's why we

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have excess beds in the state.

Illinois, I think, is blessed and truly blessed with having a lot of excellent, excellent care facilities in the state. Some beautiful facilities, may I add. But unfortunately we also have a lot of not-so-good facilities. Maybe not so good in terms -- I'm not going to speak of quality, but just maybe in terms of physical environment, or we have the product where we still have matchbox-type facilities, 200, 300 square feet per bed, small facilities. You know, the trend is changing. Everybody wants private rooms, you know. We still have yet today three- and four-bed wards that people don't want to go into.

So we still have the continuing problem of empty beds. How do we account for them, as -- you know, as Courtney has been trying to get to us do for the last several years -- to identify all those empty beds. It's a continuing problem, and that's the major problem that we have not yet solved. And I don't know what the answer is yet.

CHAIRMAN WAXMAN: Well, I think one

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of the things I heard Nelson say -- and, Nelson, correct me if I'm wrong -- is that on the state level the bed formula works perfectly. When it's being applied to individual planning areas, that's where the difficulty becomes.

MR. AGBODO: Yes. That's --

CHAIRMAN WAXMAN: Did you say something?

MR. AGBODO: Yes. That's right. That's right. And I also think that the empty beds might be built up by the 90 percent rule, meaning that -- 90 percent rule gives ten extra beds. And for some area they're not using that, and by not using that, I mean, it goes to what we call, you know, empty beds. That's at the state level. But when you go down to the health planning area, that equation change because of the 60 to 160 percent rules. And, you know, the data show that evidence.

MR. PHILLIPPE: Could I make a comment?

CHAIRMAN WAXMAN: Sure. Tim, go ahead.

MS. PHILLIPPE: This is Tim

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Phillippe.

First, I guess I -- what I said before -- I'll say some of what I said before. The formula is great, and I'm glad we have great mathematicians to do this work rather than me because it kind of reminds me of graduate school, and I don't have fond memories of those statistics classes.

However, first, the bed need formula is great by itself, but it would work if beds were gasoline, okay, because it assumes a bed is a commodity and it's the same everywhere. Right? And the need is fixed based on the commodity. So if we're working with gasoline, you know, you can use it. Gas is gas. Cars need gas. You can look at populations and miles per gallon and all that.

One of the problems we have is what other people have said: It's not the same from bed to bed. And so the fact that it's different drives use. You know, I know this in my own experience, and I would bet it's true in some locations in the state where a number of new products have been built. When there's nice, new

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places to go that look more like assisted living, more people stay there and the use goes up. In locations where it's not as nice -- not because the people don't care about quality. Maybe it's just the way the building looks or where it's located -- then the use goes down.

We have that issue that's always going to vary because, if you came in -- I believe personally, if you went into an area in some locations and you built new buildings, you would see the use go up. That's been my experience, and I imagine that's true. Because, in my own experience, when we built a new building that's what people want, what we find is they won't go home like we thought they should. You know, we were expecting them to go home, and they were fine staying there. They met the criteria. But in other settings they would choose to go home or assisted living or something different. So I think that varies.

We also have the Medicaid issue that we always talk about that skews everything when that's the predominant payer for the number of people -- it's the majority of people being --

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with a payer that's -- some people would say it's not adequate for quality of care and a quality of building.

Then to go to Judy's question, I do think our goals -- no offense to anybody here, but I think our goals are different in the room. They're not clear and unified. It's nice that you can accomplish something and you know what you're trying to do. I think some people and some organizations would like to see the ability to build new places or expand more for a variety of reasons. I think there's pressures in the state to not have any new building because they find census is a problem in their buildings, and they could be more efficient -- in some public policy perspective too, you would say we could be more efficient so the Medicaid rate maybe makes more sense if all the buildings were full.

So I do think that as a group sometimes the conversation varies because we're not clear what we're trying to accomplish, you know. Some -- like me, I prefer, whatever we do, it be predictable. It's not so much I need beds or changes. I just want to be able to predict

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whatever you're doing, and I think some people are like me as providers. We just want to predict this is what's going to happened. If we invest this, we know it will have this kind of return for our product.

So I do think it would be useful if we actually could come together on what we want -- what our goal is. Are we wanting new product? Some people want innovation, and the goal is actually to do things in the state policy -- public policy that would allow more innovative programs in more customer-oriented settings.

CHAIRMAN WAXMAN: I think you're right.

Mr. Foley.

MR. FOLEY: You know, you're absolutely correct, you know. I mean, we've been trying to deal with this issue, obviously, for a long time. You know, again, we do have --

Well, let me interject a comment first directly to you, Tim, on a personal experience, if I may for a second, please.

I recently lost my dear, sweet mother-in-law who was residing in Tim's facility

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in Springfield, a Christian home facility. There's a prime example. Tim's facility offered superb care, and my family even put this out publicly on Facebook and what have you about the excellent care she received. However, the problem that we as family had at the facility was that she had to share a two-bed room which was the only thing that was available.

The new addition that was built on the facility was indeed all private rooms, but that was for your short-term, Medicare, rehab-type patients, not for long-term care. The facility did, however, subsequently remove the other person out of the room which -- during the last final days of my mother-in-law, which gave us more comfort, but at the same time this is the private room environment that I believe that everybody wants, and this is what we're trying to achieve here in the industry, I believe. We have a lot of empty beds because we have a lot of these old facilities.

And, Tim, you hit the magic word, I think -- "innovation." We need to get back on that track again. I think -- and, again, it goes

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back to what I said earlier -- what is it that the Motherboard really and truly wants? Do they want to see innovation? Do they want to see our existing facilities modernized? Should there be review criteria for modernization? We need to be careful. Just because they want to modernize, should they really modernize? Is the population growing in that area? If it's not, maybe they should not modernize. Why throw away good money? I don't know what those answers are, but I think we need to get back on track in terms of what we're doing.

CHAIRMAN WAXMAN: Courtney, is it possible to invite Kathy Olson to our next meeting?

MS. AVERY: Of course. I wrote that down.

CHAIRMAN WAXMAN: Okay. For those of you that don't know, Kathy Olson is the chair of the Motherboard.

MS. AVERY: And I'll just say real quick. Usually what you describe, Chuck, was that we as the family member of the person in a facility wants that single-room independence, and

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speaking from personal experience with a grandmother who is doing that, when we moved her, she stopped thriving. She was in a two- or three-bed room. We moved her and got her in a single room, and she declined. Moved her back, and she started to thrive again.

So I think it's more of us. From my personal experience, it's, like, single room, single room, single room, but -- and when they can't communicate that, it becomes us wanting to make that choice because we don't want to go and sit around, and there are other people -- families coming in the rooms or anything. My only problem was that it's a small room. It's not a family-centered room. But is it the best care for the patient to be in an independent single room, and I just wanted to throw that out there.

CHAIRMAN WAXMAN: John.

MR. FLORINA: Thank you. John Florina.

Just to focus us back on where Judy's questions came up -- and this is my opinion. I'm not suggesting this is the whole group. But I

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don't think our business with the methodology is done. Okay. The methodology comprises -- I'll call it a formula, which we went through in detail. The formula utilizes data and different information in points along the way. Whether it's the 60 percent or 160 percent like Nelson suggested, that still has to be reviewed because the final product of this methodology is what's driving everything we're doing here. How many beds do we have? How many beds do we need? We don't know that.

So it's -- I'm telling you it's my opinion that we haven't finished our work in dealing with the methodology and changing those factors within it that need to be addressed. When we start with a methodology that is accurate that we all can agree on -- or hopefully agree on -- then we have a starting point to deal with the other issues that this subcommittee may need to deal with. But my involvement initially was to make sure that we're starting from the right point, and that's with a methodology that's usable, that meets the needs of the people of the state, and that's my opinion, but that's what I

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think is important.

CHAIRMAN WAXMAN: I think we all kind of come to that same conclusion, but we still got the basic problem of how many beds -- licensed beds are not in use, and I think until we can get a handle on that number, we can't do much more than what we've already done.

Judy.

MS. AMIANO: This is Judy Amiano.

I would make the recommendation, then, that a group of people who are good with numbers take a look at the input points or the data elements that go into the methodology and meet aside from this group and come back with recommendations of, you know, what each of those points look like and further ferret that out.

MR. FLORINA: I'll second that.

CHAIRMAN WAXMAN: Judy, were you actually making a motion?

MS. AMIANO: I was making a recommendation; so if you want it as a motion, it could become that.

CHAIRMAN WAXMAN: Since it has a second, I think it is a motion.

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MS. AVERY: And this is Courtney.

So for lack of a better way to put it, I hate to even say workgroup or subcommittee again --

MS. AMIANO: Ad hoc group.

MS. AVERY: -- but -- ad hoc group, all the above. So maybe a methodology workgroup or something like that? Is that what you're describing?

MS. AMIANO: Yeah. I'm suggesting that people who have a competency in understanding data and elements, you know, work with Nelson -- you know, have Nelson be a part of the group -- talk about those data elements and -- because I think until people get some comfort level around that, we're not going to be able to move this forward. I'm all about taking it apart piece by piece, fixing it, putting it back together. All I'm recommending is, if people have problems with it, then let's figure that part out and keep it moving forward.

MS. AVERY: Okay.

CHAIRMAN WAXMAN: Okay. So we have a motion. We have a second.

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All in favor --

Alan, I'll come back to you in a second.

All in favor?

(Ayes heard.)

CHAIRMAN WAXMAN: Any opposed?

(No response.)

CHAIRMAN WAXMAN: Okay. So we need to create, for lack of a better term, an ad hoc subcommittee, workgroup, all of the above.

Alan, you want to go?

MR. GAFFNER: Just that I --

CHAIRMAN WAXMAN: Chair? Do you want to be on it?

MR. GAFFNER: Only if deemed it could be helpful.

I really appreciate that because I just wanted to come back to -- and, John, you said it perfectly. As I read through the documents we had in preparation -- and I just skimmed through some of them while the discussion was underway -- I think there are areas referenced by those that submitted them that were not addressed in the breakdown that we just went

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through. And I don't mean that at all critically of Nelson's explanation. And even his findings indicate here are some other possibilities that could make a very significant difference.

So I -- speaking for me, I believe that the exercise we went through in reviewing the 32 pages does not indicate that the formula is perfect or that it can't be improved or we shouldn't be focusing on it.

So thank you for the authors of that motion and the second because I believe that still is the key to the ability of the Planning Board to make good decisions and for us to provide the facilities and the care throughout the community.

Thank you.

CHAIRMAN WAXMAN: I will go back to the two people that came up with this.

Judy, do you want to be part of it? You've done an awful lot of work on --

MS. AMIANO: No, I would not like to be part of it because I don't think that's one of my core competencies in terms of data, but I think people like Steve, you know, who works in

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data all the time. You know, I mean, this should be around "Do you have a core competency in understanding data and how it works?"

MS. AVERY: And I kind of -- this is Courtney.

I kind of came up with a list, but it's so male heavy.

MS. HANDLER: You know what? I would do it. I would be glad to participate in it.

CHAIRMAN WAXMAN: Steve, can I ask you to chair?

MR. LAVENDA: You want to me to chair? Sure. Why not.

CHAIRMAN WAXMAN: Okay. And then according to the bylaws, you really get to pick the rest of the people.

MS. AVERY: Can I make suggestions? Okay. I --

CHAIRMAN WAXMAN: Anyone who wants to volunteer can put their name out there.

MR. MORADO: And it actually does need to be by a vote that he's appointed chair.

CHAIRMAN WAXMAN: I just voted for him.

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COURT REPORTER: All right. We're getting out of hand up there. You're just talking amongst yourselves.

MR. MORADO: This is Juan Morado. We do need to take a vote appointing the chairman. The subcommittee needs to vote on that. So if someone wants to make a motion to that effect. The second, we can --

MR. PHILLIPPE: So moved.

CHAIRMAN WAXMAN: Okay. We have a motion. Need a second to the motion that Steve be chair.

MS. AMIANO: This is Judy Amiano. I would second.

CHAIRMAN WAXMAN: Okay. All in favor?

(Ayes heard.)

CHAIRMAN WAXMAN: Opposed?

(No response.)

CHAIRMAN WAXMAN: Okay. So Steve has been duly elected as chair of whatever it is we're going to call this.

Courtney, has some suggestions as to who should be there.

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I also would say anyone who wants to volunteer --

MS. AVERY: It's always open. Of course, staff, Nelson, and I didn't talk with Bill or Mike Mitchell about this, but Mike Mitchell or whoever else from IDPH will be a good representation. I know Bill Bell has some experience with it and will cover one of the associations. I'm not sure which association John represents, but I thought of John. Maybe Charles Foley, Steve, and Carolyn.

MS. AMIANO: I'm not suggesting that there has to be someone from every association.

MS. AVERY: Well, I'm trying to head off any issues. That lady on the phone will be after me.

MS. AVERY: It is a workgroup to bring recommendations. This board holds the power over what happens with that. So, you know, I think it needs to be people who can address and deal with the problem.

MS. AVERY: Well, I know John has that background.

MR. FLORINA: I'll be glad to

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participate, but I'm not representing any one particular organization.
MS. AVERY: Okay. So I can drop that part if we all agree that we won't have a backlash that this was heavy this, heavy that, this one didn't have representation. And there's always the open possibility to submit any written comments and give feedback and attend, and I know that's one of your pet peeves, Judy, because it seems to be, when there's a five-member committee or workgroup, it's 30 people that participate. So we'll try to limit that.
Anyone else?
MS. CUNNINGHAM: Yeah. This is Kelly Cunningham from the Medicaid agency. Sorry. I was a little late this morning, and I missed introductions.
I just wanted to volunteer to participate. I know that Minimum Data Set, MDS data, is one of the inputs for patient days. We do have some expertise in that area within Medicaid, and so I would be happy to make sure that we're represented to help talk through whatever questions might arise.

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MS. AVERY: Great. Thank you.
CHAIRMAN WAXMAN: Okay. So we got John. We got Steve. We got Carolyn, Kelly. Who else?
MS. AMIANO: I thought you said Bill Bell.
MS. AVERY: Oh, I did. Bill, what's you're feedback? Bill Bell.
MR. BELL: I am no mathematician. I will help out any way I can. I can't even spell statistics, you know, so -- but I will try.
MS. AVERY: We'll attack you for feedback.
MR. BELL: Okay.
MR. GAFFNER: And I think you said Charles.
MS. AVERY: Oh. What is your thoughts --
CHAIRMAN WAXMAN: Charles, did you want to be on it?
MS. AVERY: Can you contribute?
MR. FOLEY: If I could help, I'd be more than glad --
MS. AVERY: We'll use you for

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advisory.
MR. GAFFNER: Well, I think that would be very appropriate. They had authored -- their organization with their data person -- the white paper. So I think that would be appropriate.
And that is Alan Gaffner.
And, Courtney, I just want to add I appreciate your sensitivity, and I view that as important to the representation of all groups because just since I've been here since November, I think we lost some time regarding getting to even the point we are now in the bed buy/sell program because it did not have involvement from all the associations. So I thank you for your sensitivity.
MS. AVERY: You're welcome.
So one, two, three, four, five.
CHAIRMAN WAXMAN: (Inaudible) open meeting.
MR. MORADO: I was going to say that.
This is Juan Morado.
We can have this many members. That will be fine. We probably need to make the calls

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open and just post them.
MS. AVERY: Okay.
MR. FLORINA: Question. Florina.
Are we assuming that Nelson is part of this?
MS. AVERY: We are.
CHAIRMAN WAXMAN: We are.
MR. FLORINA: I didn't hear his name.
MS. AVERY: We are. Nelson and Mike Mitchell.
MS. CREDILLE: This is Cece Credille with IHCA.
You know, we were asked to submit some feedback and et cetera before the meeting, and so what IHCA has put forward is actually talking about Ohio's bed need formula, which is very simplified. It does not rely on at all the occupancy issue and licensed and unlicensed beds. It takes it off the table and simplifies it.
So I would ask that this workgroup look at that as a model as well because we've analyzed this document -- which, Nelson, I, like the others, applaud you. The level of detail is fabulous and helped provide a sound

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understanding, I think, of what's going on in the State of Illinois. But I would -- I'm where John is. There's still other options and still methodologies to discuss, but we -- we prepared that, and I would ask that someone please consider that.

MS. AVERY: And my next thought was -- I don't think we moved off of number five yet; right?

UNIDENTIFIED: We have not.

MS. AVERY: Okay.

-- was to go over and get feedback from the associations. So their impact statements that they sent in. So we just kind of got a little off track there.

UNIDENTIFIED: Is that on the agenda?

MS. AVERY: It's kind of grouped in, but it was sent out with the materials with Nelson's presentation.

CHAIRMAN WAXMAN: There was a statement from LeadingAge. I don't know if someone wants to represent LeadingAge?

UNIDENTIFIED: Yeah. It's self-explanatory.

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CHAIRMAN WAXMAN: Fine with me.

IHDA had a paper. Bill, do you want to talk about that, or are you satisfied that it's self-explanatory?

MR. BELL: I think Cece kind of explained it. You know, it -- like I said, it's pretty self-explanatory, pretty simple. Just basically taking what -- and we've had a lot of conversation about the Ohio program, and just basically took theirs and how it would play into Illinois. So it was just another option.

MR. GAFFNER: Question --

Alan Gaffner.

-- for Bill.

Bill, I think you based yours on -- was it 40 beds per thousand?

MS. CREDILLE: No. 50 -- 51 point something.

MR. BELL: I think the national average is 40.

MS. CREDILLE: So it's 51.

MR. GAFFNER: And the logic on that number was --

MS. CREDILLE: 90 percent -- 90

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percent of utilized beds in Illinois --

MR. GAFFNER: Okay.

MS. CREDILLE: -- lands you at 51.

MR. GAFFNER: Okay. All right. Thank you.

CHAIRMAN WAXMAN: Paul, you issued a document. Do you want to discuss it with the group?

MR. CORPSTEIN: I'm sorry. You're referring to me?

CHAIRMAN WAXMAN: Yeah.

MR. CORPSTEIN: I think my comments are pretty plain. I don't think there's any ambiguity in any of that. I also think, with the passage of 3510, my points are moot. So I'll just let it stand. Thank you.

CHAIRMAN WAXMAN: Anyone else need to --

MR. CASPER: Well, this is Bill Casper.

I just have one question. Since, Nelson, you've identified this 60 percent/160 as an issue, my question is that where did that come from? Is that some -- is that a statutory

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requirement? How did that evolve into the bedrock of the bed need formula.

MR. AGBODO: Yes. It is a statutory requirement, and I have the language here.

MR. CASPER: Okay. That was just my question, though -- is this going to require legislation to make those kinds of changes, and, obviously, the answer is yes.

MR. BELL: Statutory or in the Code?

UNIDENTIFIED: In the Code. It's in the Code.

MR. CASPER: It's what?

MR. BELL: It's just the Code. It's just in rules. It's not in statute.

MR. CASPER: Okay. It's rules.

MS. AVERY: So we don't have to make that change.

UNIDENTIFIED: We can change the rules anytime.

MS. AVERY: Yeah.

MR. GAFFNER: Alan Gaffner.

I was just going to let the chairman know, as I have kept both Courtney and Claire informed, HCCI has not submitted any comments on

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the bed need formula yet, and I've apprised both of the staff regarding that. They have been focused on the Medicaid budget issue. In fact, actually bringing additional people involved. I was loaned to them for some of that assistance for about a month. So I appreciate, Courtney and Claire, your understanding of that, and they have provided opportunity for that to be submitted and will be welcomed.

So I just wanted to offer an explanation, Mr. Chairman, why there was not an official document from the Health Care Council of Illinois.

MS. AVERY: And I should have stated that. So thank you.

MR. GAFFNER: Oh, I'm sorry, I didn't mean to preempt that.

MS. AVERY: No, I forgot.

COURT REPORTER: I'm sorry. Courtney, I didn't hear you.

MS. AVERY: Oh, I just acknowledged it and said I forgot.

CHAIRMAN WAXMAN: Housekeeping: Courtney, do you when lunch is coming?

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MS. AVERY: It should be here.

CHAIRMAN WAXMAN: Okay. Then it's 12:00 o'clock. I would suggest we take a break, and then reconvene -- working lunch? Reconvene when our lunch gets here so we can work through our lunch hour.

If I remember correctly, we have to vacate the room at 1:30?

MS. AVERY: Yes. So we will finish on time or before.

CHAIRMAN WAXMAN: We'll finish on time or before. So we'll stand adjourned for a few minutes until everyone figures out where lunch is at.

(Lunch recess.)

CHAIRMAN WAXMAN: I believe we have completed item 5 unless someone else has any questions for Nelson or we want to go back and talk about the white paper or we can move on to another agenda item.

MS. AVERY: And those five for the group, at the end we'll come up with a date for you guys to meet, and I'll just get those dates to Kelly.

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CHAIRMAN WAXMAN: Next on the agenda is Judy, but I'll give her -- we'll let her finish lunch before we make her talk.

So let's look at a date for the next meeting, maybe.

COURT REPORTER: Are we going to be on the record for this?

MS. AVERY: Just the date. Once we get the date.

(Discussion off the record.)

MS. AVERY: 13th of August.

CHAIRMAN WAXMAN: Okay. That takes care of that.

Anyone have any other business they want to bring before the group? Any other business before the group.

(Inaudible.)

CHAIRMAN WAXMAN: I'm moving down the agenda item, other business, item 7.

Chuck, did you have something?

MR. FOLEY: I just -- food for thought here in talking with somebody earlier, after we had taken a break, on the possibility of looking at bringing home health care under CON

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review. And I just happened to be thinking about that and wonder would that be good or would that be bad, and I guess I would just like to bring it out on the table here just to see what everybody's thoughts and feelings might be on something like that.

CHAIRMAN WAXMAN: Why would you pick home health versus assisted living or sheltered?

MR. FOLEY: We already talked about assisted living and shelter. I mean, I -- obviously, I think that they should be under CON review, but legislatively it can't happened unless we change -- you know, change the law on this.

But I think that's a very, very important component of our work here in terms of looking at the whole picture rather than just part of it; so -- but I'm just going to set that aside, and I was just thinking about home health agencies. What impact does that really and truly have on long-term care, and should we or should we not be looking at a possibility of bringing that under CON review. I'd like to hear comments also from the staff, if at all possible, if they

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have any thoughts on that.
MS. AVERY: When you say bring it under review, as to issue a CON for establishment --
MR. FOLEY: To establish a -- to establish a home health agency.
MS. AVERY: Okay.
MS. O'DEA EVANS: May I -- are you talking about home services --
COURT REPORTER: Who is speaking, please?
MS. O'DEA EVANS: Pat O'Dea Evans.
Are you -- Chuck, are you asking about home services agencies or medical home health?
MR. FOLEY: Medical home health.
MS. O'DEA EVANS: Okay. Because medical home health is regulated by CMS.
MR. FOLEY: Right.
MS. O'DEA EVANS: And they -- they are restrict -- they are not -- at this moment I don't think they're currently approving new home health agencies.
UNIDENTIFIED: They are not.

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MR. FOLEY: Okay.
MS. O'DEA EVANS: You know, they have their own process of determining need.
MR. FOLEY: Okay. All right.
MS. O'DEA EVANS: So anyway -- but even though the state does licensing, you know, the federal government, because it's Medicare funded for the most part, also has restrictions on those things about --
MR. FOLEY: Does staff have any other comments on that?
UNIDENTIFIED: I understand your, you know, policy desire to bring people in so that you can have information that, you know, may relate to, you know, how you figure out need for skilled beds.
MR. FOLEY: That's just what I was thinking, yes.
UNIDENTIFIED: I understand that. Politically, though, I think that would be a really hard sell, and I don't know that you'd get enough -- not saying that you shouldn't do something because it's hard politically, but I don't know if you'd get a big enough bang for

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your buck even if you were successful to make it worth it. I just -- somehow or other bringing in -- I don't know how many home health agencies there are in the state, but there's a lot. And every one of those agencies has a legislator in their district. I just think it would be a really hard sell; so --
MR. CASPER: So, you know, I think -- This is Bill Casper.
I think historically part of the rationale for -- and some states do control home services through certificate of need, but the rationale of certificate of need was because -- goes way back to cost-based reimbursement. If the state was paying a Medicaid rate that included capital, there was a reason to have a say in the building of nursing home beds because, to some degree, a built bed is a filled bed, and if it's Medicaid eligible, the state's going to be paying for it. So there's a rationale there.
I understand the issue of the impact of other services on utilization of nursing homes, but I don't know that there's a real -- there's no -- there's very little, if any, state

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money going to pay for assisted living.
COURT REPORTER: I'm sorry. I lost you. I'm sorry. I couldn't hear you.
MR. CASPER: Yeah. So there's very little state dollars, if any, paying for assisted living. So from a capital perspective and a state dollars perspective, there's not a real rationale for regulating the supply. The market is regulating the supply. And as far as SNFs go, I think you could make that argument there. Don't know how far you'd get in terms of getting legislation passed to include them.
CHAIRMAN WAXMAN: Let me go a different way.
Steve, you have a couple people in your office that specialize in home health.
MR. LAVENDA: Correct.
CHAIRMAN WAXMAN: I'm wondering if one or both of them would like to come and do a presentation to the group on the state of home health and maybe be available for some questions and answers.
MR. LAVENDA: This is Steve Lavenda.
I could ask Terry Cichon, who used to

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be the head of the Illinois Homecare Council and is a widely known expert. She would be able to answer your question, I'm sure of it. I don't -- I'm pretty sure she would be against that type of thing, but I don't -- I don't know the reason why. But she certainly could explain it a lot better than I could.

CHAIRMAN WAXMAN: That's who I was thinking of.

MR. LAVENDA: Yeah. I certainly could ask if she would like to come.

CHAIRMAN WAXMAN: Chuck, does that get you closer to what you're looking for?

MR. FOLEY: Yeah. That's fine. I was just -- you know, like I said, just had a conversation, and I was just thinking about it afterwards, and the idea did kind of intrigue me because I thought it would bring us in maybe a little bit closer to the impact that it would have on -- the home services -- you know, on our methodology itself, you know. Yes.

MS. O'DEA EVANS: This is Pat O'Dea Evans.

There is a -- you know, home health

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is very -- is short term, time limited, intermittent, and also is looked at as going to be growing more as an option. So it is being, you know, looked at as a preferred setting for people to get their care in their own home, if possible.

So there is -- because of -- the federal government and CMS has basically been encouraging hospitals to look at their total cost of care, and I'm not sure how familiar you are with that, but basically there's a formula on how much do you spend for this patient who ends up in your hospital post acutely three days prior to service and post acutely. And so then hospitals are being compared to how much their spend is, and they're realizing, "Gee, we might want to consider home health as an alternative to a skilled bed for certain patients because this will reduce our total cost of care," which now Medicare is making hospitals responsible for that number, versus before, you know, everything was silos and it doesn't matter to the hospital how much it costs Medicare after they discharge the patient.

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So there will be a trend to increase utilization of home health because of this. As hospitals become more sophisticated in trying to determine what really is the most appropriate setting to discharge a patient to and not just automatically think skilled bed, skilled bed, skilled bed. They are happy to retool how they think about their discharge planning and be much more precise about what really is needed for that patient.

UNIDENTIFIED: And plus they're being penalized for readmission. So it's in their best interest to make the right decision.

MS. O'DEA EVANS: Yes. The more accurate that decision is, I agree, the less likely of return

MR. FLORINA: Yeah. Florina again.

Pat, is there a way that that information can be tracked? That would --

COURT REPORTER: I'm sorry. I can't hear you.

MR. FLORINA: Is there a way that that information would be tracked so that we know what the impact is on the total long-term care

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picture?

COURT REPORTER: I'm sorry. With the lunch, all I'm hearing is the rattling of papers and containers.

(Discussion off the record.)

MR. FLORINA: I just want to know if there's a way of obtaining the data regarding those type of transfers out of the acute setting into home care in order to use it for evaluating the need for long-term care services that may no longer be needed in the nursing home setting.

MS. O'DEA EVANS: There is. There is. Medicare does produce a report, and it's six months old, but it's pretty -- you know, that's really pretty current data on exactly what their spend was per patient, and they do a per patient per day analysis per hospital. It's pretty -- it's -- it's a lot of data, and it's pretty accurate because it's based on actual billing.

MR. CASPER: This is Bill Casper.

The discharge infor -- hospital discharge information of anybody going to Medicare -- Medicare-reimbursed post acute care is readily available.

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UNIDENTIFIED: That's true.
MR. CASPER: Public data.
UNIDENTIFIED: It may have limited usefulness, though, because it will -- you'll have a field that says discharge disposition, but you won't necessarily know whether -- how that decision was made. Would that patient otherwise have gone to skilled or whether the disposition would have been home health to begin with.
MS. O'DEA EVANS: This is Pat O'Dea Evans again.
Yes. You'd have to be pretty sophisticated to look at, but there is also other tools that look at, with this diagnosis, what percentage go to a SNF, what percentage go home with home care, what percentage go home without any services, what percentage go to outpatient. And so you'd have to do a lot of comparison. It would be quite the project, and I'm not sure if that ultimately is going to get us where we want to go or the information we need.
But I think it's important to realize that this is a trend that is likely to continue, and there's an incentive -- whenever there's

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financial incentives, there's incentives to move in that direction. So it's just something for us to be aware of.
MR. FOLEY: Does that same report also --
I'm sorry. Charles Foley.
Does that same report also show the amount of the readmits back to the hospital from each one of these different settings?
MS. O'DEA EVANS: It's not the same report, but that information is also available, yes.
MR. FOLEY: Okay.
MR. CASPER: In addition, one of the recent -- I think it was the Smart Act that requires CMS to develop a standardized assessment tool for all post acute settings and also to begin looking at site neutral payments for post acute episodes of care. So a lot of data will be available from all of those initiatives.
MR. PHILLIPPE: This is Tim.
If I could just interject that I've also seen some of that data. However, I'm not sure if it will be great advantage for this

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subcommittee to be actually looking at that. It has value on a big picture level nationally, but markets vary based on options. And so, you know, I know, like, physician groups who take risks on bundled payments for something like cardiac events, and they will tell you they reduced referrals to skilled nursing 30 percent already and expect it to drop another 20 percent. I know of a hospital ACO that would tell me they've reduced their referrals 30 percent to skilled nursing.
But I think all of that is market specific because there's so many options out there on the bundled payment, the ACOs, is it bundled payment for a post acute provider, you know, a physician -- the bund -- I mean, the bundling and the ACOs. I think it -- the manage -- dual eligible managed care where it's -- there's so many other programs that the numbers in any one market vary based on the options available.
So I agree, though. I think the trend is away from institutional care, and even though some of us on the skilled nursing side

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think we do a better job, I've seen the readmission rates, and they're higher for skilled nursing than they are for home health.
MR. KNIERY: If I can make a comment.
John Kniery.
I think the one thing we're looking at with talking about the bed need formula and methodology, if we do this consistently -- right now it's being done every two years. If we can do it, you know, maybe even sooner than that, all those trends are then factored in and taken into account. You don't have to do a separate calculation for this program, that program, and the next.
UNIDENTIFIED: Good point, John.
CHAIRMAN WAXMAN: Anything else anybody wants to bring up?
MR. PHILLIPPE: This is just -- Tim.
In terms of looking at the future, I think the most powerful page from Nelson's PowerPoint was page 18 because you can actually ignore a lot of the formulas and you can just look at the trend line on actual use, and based on -- and that's something else that's changing.

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We could assume that that's the trend that's going to continue; right?
MR. AGBODO: Yes.
MR. PHILLIPPE: And it takes everything into consideration. Like, you -- you could do it every year, and you might get a little more accurate on it, but the bottom line is just look at the trend down, and that's the best predictor, really.
MS. CREDILLE: This is Cece Credille.
And based on that Slide 18, I will also go back to the Ohio formula because it's driven on usage in the state. So that particular formula simplifies everything and uses actual patient days. Again, ignores the issue we have of empty beds, dead beds, not used bed, whatever we want to call it, and looks at actual utilization in the state, and then projects the occupancy 90 percent based on utilization.
So I agree that that -- the graph -- Tim, I agree with you wholeheartedly. That the ceutilization is going down and would probably continue to go down given all the health care reform initiatives.

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MR. GAFFNER: And this is Alan Gaffner.
And I'd love to know -- which there are some futurists that indicate that there is this proverbial dam, so to speak, that can break that will put the AL and SL folks into the nursing home at some point. We've got this big population that is being cared for other places, and I don't think anyone has yet been able to predict or assess what that might mean.
Tim, you're absolutely correct in what it's showing with the trend line. I guess how we can, with certainty, say there won't be some other increases in utilization, and that, I think, is a real challenge for us -- to be able to say that there will be no swing of the pendulum the other way that could increase our utilization.
CHAIRMAN WAXMAN: Chuck.
MR. FOLEY: Yeah. I'd like see if there's a possibility -- and I guess, again, in terms of food for thought, if there's way where we could, for every new facility that's being built in Illinois, to maybe somehow require

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them -- I don't know whether that's possible or not -- to have a percentage of total beds in assistant living, slash, supported living in order to provide that continuum of care in order so that residents don't have to move from their environment. I don't know if that's possible or not. Just food for thought again.
CHAIRMAN WAXMAN: It is food for thought.
Any other comments?
I think Judy has enough time to finish the agenda item.
MS. AMIANO: So I guess I have just -- this is Judy Amiano.
I guess I've been asked to report on the ad hoc group which met last on March the 9th. So that's been some time ago; so I have to refresh my brain. Actually, it's March 24th that we met. Somewhere around in there. I don't know.
At any rate, so this was the -- the three associations and Claire of staff was at the meeting -- at the couple meetings that we've had since the last time that we got together.

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So I guess that, you know, to report out, there was very, I'll call, hearty discussion around a number of topics. And I think the important thing to bring forth is kind of some general consensus kinds of items.
The first was a general agreement to change what we've been calling, you know, the buy/sell program to a buy/sell/transfer program.
The second is around the issue of moratorium, and there's agreement that, if there's a moratorium, it's only associated with the buy/sell/transfer program. That just putting a moratorium in place absent a program is not acceptable. So there's agreement with that.
We were all in agreement that the bed need formula should be addressed, which the work of the group -- the other subgroup is going to take care of. There was, however, not consensus that it was so critical that that needed to be addressed before the buy/sell/transfer program could go into place. And I think that was based off of the conversation of there's been a lot of projects approved over the course of the last five years, that we've heard that data before,

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and, you know, there didn't seem to be a need to put another few years on hold as we deal with the bed need methodology in order to think about how to implement the buy/sell/transfer. But there was not agreement amongst the group around that.

That there is a need to consider geography when developing the program. We could not agree on whether that was statewide or by HSA or by some newly defined type of boundary during the implementation of the buy/sell/transfer.

We did all agree that the program should be implemented statewide rather than selecting a trial area, seeing how that would work, and then moving it forward. Again, for expediency purposes, I think, once the program would be designed, implement it statewide.

The rest of these are pretty easy. The beds are not owned by the purchaser until approved by the Board.

That there should be a standard contract. You know, let's not create an arena where, you know, it adds expense and whatnot. Let's just draft a standard contract that every -- all constituents -- both buyer, seller,

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and the state -- are happy with and is simple, and it saves us all legal dollars.

That a buyer has 18 months to start construction of any new project, and that's very similar to rules that are currently in place. That at the end of that 18-month period, if you didn't -- if you got approval for it and you didn't move forward, you -- use-or-lose rule within that 18 months.

And then there was consensus that any funds raised or money transfer between a buyer and a seller was solely the responsibility and the private matter of the buyer and seller, that the state should have no role in dictating price points or how funds are used by the seller.

But those are the general points of consensus.

CHAIRMAN WAXMAN: Thank you.

MS. AMIANO: You're welcome.

CHAIRMAN WAXMAN: Questions or comments on any of these nine points?

MS. AVERY: This is Courtney.

Not so much the nine points, but the next steps and if we really want to continue with

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this or we're going to hold it. Not eliminate it, not get rid of the issue. Do we want to focus on something else, or do we want to still do it concurrently? That is, the subcommittee workgroup planning to meet again. The ad hoc group.

MS. AMIANO: The ad hoc group was going to -- you know, we had a responsibility to report to this group, and so that's what we're doing today. We have no meeting scheduled moving forward.

You know, I would ask that, if you want that group to move forward, it's with a very specific what it is you want the group to accomplish because we, like the larger group, you know, can do an awful lot of talking around issues. So if we're trying to move forward, it would be with a very specific task of what you'd like the workgroup to accomplish.

CHAIRMAN WAXMAN: I think Courtney raised a very good question. Do we want to look at this and the bed need formula together, or do we want to concentrate on one or the other? I think the committee needs to make that decision.

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So I'm open to hear.

Chuck.

MR. FOLEY: I'm kind of torn between this whole thing with the buy/sell/transfer concept. I mean, I do see a lot of advantages to it as well as some disadvantages as well. I guess I'm just of the personal opinion that, if the buy/sell/transfer concept was, in fact, something that we should seriously have, we would have had this accomplished a long time ago. If this is something truly that the industry really and truly wanted, the industry would pull themselves together and would have had this accomplished a long time ago.

I think we have some other issues -- i.e., the bed need formula, the methodology itself -- that we need to really focus on and pay a lot of attention to. I don't think we need to throw this out -- the buy/sell/transfer concept. There might still be some merit on it in the future, but I think for now we need to put our eggs in one basket and let's concentrate on the bed need methodology. That's my personal opinion.

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MS. AMIANO: This is Judy Amiano.
I would just remind the group that -- and I think it was prior to joining, Chuck -- that this board -- this subcommittee did have a formal vote -- motion and vote to move forward with the implementation of a buy/sell/transfer program. So the work of the committee was based on a vote by this subcommittee that was communicated to the Board that we were moving forward with a buy/sell -- at that time it was buy/sell program but buy/sell/transfer program. So that ad hoc committee was formed because the bigger group got stuck. And so just as a reminder to the group.
MR. FOLEY: Well, again -- I'm sorry. Go ahead.
MS. AVERY: This is Courtney.
It went a little bit further than that -- the vote. It was also in the legislation to do an evaluation.
MR. FOLEY: And, again, I think what I just said was I'm not saying that we just forget about this altogether. No. I still think there's -- there can be/could be some merit to

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this. I guess I'm just saying, for the time being at least, let's just put it aside and concentrate on the bed need methodology, and then come back with this at a later date.
MS. AMIANO: I would respectfully say that, if there's going to be some recommendations by January of '16 or January of '17, whichever one it is that it falls -- and I'm not sure which date this falls into -- that time is of the essence because things move relatively slowly in these discussions.
MR. GAFFNER: And this is Alan Gaffner.
And I would respectfully disagree. That I believe that -- although there was not consensus on which had to come first, that there was some pretty definite consensus that the bed need formula needed to be addressed as a focus. Because we've already found today through the staff evaluation that there are areas of the state that reflect need where beds aren't available and vice versa. This directly touches the bed buy/sell program, and there's no need to have a bed buy/sell program if the bed need

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formula can address the access issue. So there's, I believe, no need to have a parallel track until we've seen what can be done with the bed need formula.
MS. AMIANO: Yeah. Again, there was not consensus that the bed need formula was critical to moving forward with the bed buy/sell/transfer. How do you implement it? What's it look like? So there was not consensus around that, that it was so critically important to the buy/sell program. So I'm just -- for point of clarification.
MR. FLORINA: John Florina.
My understanding is that these nine consensus points were from the ad hoc group. So it's not part of our discussion as a subcommittee, and I have questions and input on a number of the items too, but we're not discussing it among the whole subcommittee.
But in general, in looking at it, the buy/sell and now adding transfer is dealing with the symptoms of the issue we've had with excess beds and the distribution of beds throughout the state. So I'm just questioning if it makes sense

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to implement something as maybe a Band-Aid or a temporary situation, temporary relief, because of the underlying issue not being addressed, and the bed need methodology would address, in my mind, the underlying issue rather than just dealing with the repercussions of those problems.
CHAIRMAN WAXMAN: Can you clarify what has to be to the Board on January 1, 2015, versus what has to be -- 2016 versus 2017, according to the Act?
MS. AVERY: Recommendations to change, keep the status quo -- it's pretty vague -- regarding the bed need formula.
CHAIRMAN WAXMAN: On 2016?
MS. AVERY: 2016.
CHAIRMAN WAXMAN: Okay. And 2017?
MS. AVERY: (Inaudible).
UNIDENTIFIED: 2017 was the bed need formula.
UNIDENTIFIED: And the health service are boundaries.
MS. AVERY: Oh, yeah.
CHAIRMAN WAXMAN: Okay. So what's 2016?

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MS. AVERY: 2016 is vague also.
UNIDENTIFIED: General recommendations.
MS. AVERY: Right. If there's a rule change that needs to come before the Board, things of that nature. I think there is a mandate that we review the rules every couple years anyway.
MR. PHILLIPPE: Could I just also, Mr. Chair?
CHAIRMAN WAXMAN: Yes.
MR. PHILLIPPE: First, I wanted to ask if there's a reason why we have to actually just focus on one thing, and it's partly because the bed need formula is actually a scientific, mathematical issue. It's less to do with people's feelings and positions than it is understanding the data and if there's things that can be changed in the formula, which I think you've already -- Nelson's already identified some of those.
So I don't know why we would have to just do this for the next six months and nothing else because most of the work is not the

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relative -- it's not based on positions or theory. It's really more based on the facts and the formula itself. And it seems like, like Judy said earlier, really, the people on the task force need to be people that can handle the math, I think, in some ways because that's what you're going to be getting into -- is really how to make a more accurate predictor.
So I don't know why we couldn't continue to do the bed buy/sell/transfer also, particularly considering all the things we said before about the fact the subcommittee agreed they wanted to move in this direction, it was just a matter of defining how, the conditions, and there's a lot of work being done by this -- even the recent task force, the workgroup, and if we just put it off for six or eight months, what will happen is -- or a year -- you'll have to start all over again with new people, and they'll argue the same points all over again.
And if you've got industry --
(Laughter heard.)
MR. PHILLIPPE: Right?
And if you've got the three

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associations representing providers that have come to mostly a consensus on things, I would think we could kind of push it forward. And on anything like this, I don't think we're going to get a hundred percent consensus on everything. So even when we had the vote about moving forward, I don't think it was a hundred percent back then. So I would still think we should do both at the same time so we don't lose all the work. It's kind of sad to have the work that Judy and the others put in on this workgroup kind of disappear because we put it off for another year.
CHAIRMAN WAXMAN: I tend to agree with you. I mean, again, you know, we carved out a group of, like, four or five people to work on the formula, which means that there's ten more people on the committee that can tackle the other issue. So I think we should be moving on both issues simultaneously.
Our recommendation, if I heard correctly, on the bed formula is not due until 2017. So we have a sufficient amount of time to drill down and figure out what it is that needs

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to be changed in that regard.
But I certainly think we should move forward on the other issue and have a plan to present to the Motherboard and let them at least, you know, hear what we're thinking as a group.
And, again, from sitting in this chair for the last 12 years, I totally agree that you will not get consensus on many issues other than it's time for lunch and time to adjourn.
But I do think we should be moving forward on both regards. That's my personal opinion and not necessarily as chair.
MR. CASPER: This is Bill Casper.
I guess I would echo that position because, having sat on one subgroup that was working on this issue -- and I know it was discussed in the current group -- the transfer, sale, or buying of beds -- these are beds that have already been licensed, have already been approved. We're not dealing -- we may be dealing potentially -- although that's an open issue -- with the bed need formula in terms of where they move to from where they currently are. But that being said, these are beds that have already been

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approved and licensed under any existing regulatory forum.

So we're talking about a mechanism for allowing for the sale and/or transfer of those beds to allow people to move forward with a variety of different projects and programs that they have in mind. So I really think that there is not a need to link the two.

And that, particularly since the recommendation on the bed need formula may not be going to the Board until January '17, to just take a big giant step backwards and take this off the table for now would be a mistake.

MR. GAFFNER: Alan Gaffner.

I would just add, again, that at least everything that I've heard about the bed buy/sell was tied to access, and the bed need formula, the whole purpose is to talk about access. I agree with John that the primary focus should be addressing a methodology that is key to what the Planning Board uses before there's an auxiliary program in place to deal with access issues, especially when we've already identified and had staff point out some things that could

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make a key difference in finding those there. I don't believe there's any need to be using dual tracks because everything that's done right here can be picked up immediately, whether it's next month or six months from now.

MS. CREDILLE: This is Cece Credille.

With all due respect, the folks that are supporting -- which I would support continuing to explore buy/sell -- have been on the committee the longest. So we have been working on this for three years. So to put this on the side till January 1, 2017, when we can come to some consensus on the bed need formula, flies in the face of what we wanted to do and all the work we have done.

And, again, I would say, as I have said probably in the last number of months of minutes, other states have buy/sell. It's a transfer. It's a voluntary program. And other states are functioning quite well with a buy/sell as a component of the long-term care -- level of care.

MR. CASPER: Bill Casper again.

I guess I would challenge Alan on the

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concept that access is the only issue that's on the table in relation to the buy/sell program.

There's the issue of being able to upgrade programs, upgrade buildings, upgrade facilities without adding to the bed supply, and so I think that's -- I don't know that anywhere in either our charter or legislation or the discussion has access -- in my history of this issue has access been the only issue.

UNIDENTIFIED: I agree with you, Bill.

CHAIRMAN WAXMAN: I guess I keep thinking about something Judy said earlier, which is we, as any good committee, need to focus and move forward. And I think this committee is very talented and deep in abilities and people to work. We can do two things and stay focused on two different things and keep moving forward on both issues.

MS. AMIANO: This is Judy Amiano.

You know, how I would see it -- maybe it will give comfort to some folks around the room -- is, as we're thinking about, you know, this group will work on how to implement, what

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does it look like. So all you simply have to do is say we have too many beds in Section A and not enough in Section B. How do we make it work without worrying ourselves with the bed need formula. Because really what we're talking about is functionally, operationally how do we transition to a program which will take a long time for the various groups to come to some consensus on; so --

You know, I -- candidly, if we take a pause for six months, I would agree with whoever said it. It will be like starting all over again, and I'm not sure that some folks in the room have the energy to do that yet one more time.

CHAIRMAN WAXMAN: I agree. Tim said it, but I think we all kind of have been there.

MS. AVERY: So how about --

This is Courtney.

-- that staff will go back and look at everything, make some concrete goals, hopefully, with some deadlines, and what we need to do and how we need to do it, bring it back to you all for consensus on it and start. Or we

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could e-mail it or whatever. But as you said earlier, lay it out with the purpose of the subcommittee, the ad hoc groups, what are the objectives, and some dates and targets that we need to hit.

MS. AMIANO: If I could add one thing.

This is Judy Amiano.

If you could have a conversation with the chair of the Motherboard and just get a sense -- because there's some new players there. You know, what is it you want from this group.

CHAIRMAN WAXMAN: We -- we -- I'm sorry, Judy. We did talk about inviting Kathy to join us at our next meeting.

MS. AMIANO: Well, I think even preparing kind of the overall objectives from -- that would be helpful if staff would take --

MS. AVERY: And we do get that question: Are there any recommendations from the subcommittee yet? So we have gotten that question.

MR. GAFFNER: This is Allen Gaffner.

I'm a little uneasy -- although I

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welcome the Planning Board's direction. That Board has a completely different face right now with many new individuals. I have to question how up to speed or informed they will be in providing direction for us as a group that's been intimately involved. I welcome what they --

MS. AVERY: It won't be -- it won't be --

MR. GAFFNER: No. No. I welcome what they --

MS. AVERY: -- anything outside of what you were charged to do. They won't come up with any new --

CHAIRMAN WAXMAN: I think it's a matter of -- and, again, to be honest, when Dale Galassie was chair, Dale and I go back a million years, and we had access -- I had access to that, to the feelings and thoughts of the Motherboard.

With Kathy Olson now in charge, I don't have that. So I haven't been able to sit with anybody and feel where they're at. So I think it's a matter of open discussions, both sides hearing where we're -- what they're thinking and what we're thinking. Let's make

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sure there's some agreement.

MS. AVERY: And the staff -- I couldn't have done a better job with at least -- I know we've only had, like, two reports that have gone to the -- to the Board, but new members are up to speed. Again, I know everything is on the website. Not everyone reads them. But when we go through orientation, we spend time on the subcommittees and the discussion. So they may not be minute by minute, second by second, but they know what your charge is. And I don't think there will be any additional charges outside of what Senate Bill 1905 required you to do and now what House Bill 3510 is requiring us to do.

MS. AMIANO: If I could ask that you pull out those items, you know, so that we have them as a list in front of us always, you know --

MS. AVERY: From the legislation.

MS. AMIANO: From the legislation. That would be super helpful.

CHAIRMAN WAXMAN: Since we're hitting the deadline of whatever is going to happen in this room -- and we may not want to be here when that happens, whatever that may be -- let me just

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kind of summarize, if I can.

We do have a date of August --

MS. AVERY: Yeah. And I was waiting. We don't have confirmation of the rooms yet, but August 13th.

CHAIRMAN WAXMAN: Okay. August 13th is our next meeting.

We have a new ad hoc working group, subcommittee, special people with math backgrounds -- God bless them -- under Steve's direction to continue the discussion on the bed formula.

We are going to move forward with looking at buy/sell. Judy, do you think your group needs to have a discussion before the next board meeting, or you want to wait for Courtney to put stuff together?

MS. AMIANO: Well, I think it's a matter of we only work through the work that this committee would charge us with and so --

CHAIRMAN WAXMAN: We'll determine that at the next board meeting?

MS. AMIANO: I'm -- that's not for me to decide.

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MR. FOLEY: Let me go ahead and suggest, if I may, Judy. Since it sounds like it's a consensus that we want to move along with this, if you guys have the time, to come back at the next meeting and a little bit more detail on your nine points as to how you would envision such a program, you know, to take place and your timeline, you know, for a program to take place, that would be helpful so we could, you know, look at it and have some meaningful discussions with you then.

MS. AVERY: This is Courtney.

Is it okay if we look at it and maybe take four of them? And then take the next four? Or do all nine? Present them to you and what we would need to do in order to, like, pan out the geographical areas, what that would mean, how it would look, how it would work within the agencies.

MR. PHILLIPPE: If I could suggest, I think that's a great idea because I remember from the past, when we try to do all nine points at one time, people bounce around and we don't get a focus. So starting with a small list and work

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through those and get those done and then move on would make more sense. And it'd help the staff probably to be focused in their time also.

CHAIRMAN WAXMAN: Thanks, Tim.

The other two things I'd like to address, again, as chair of the committee and representing the entire committee, to thank Nelson and everyone else that participated in the drawing of -- development of the document and the explanation. Our sincere thanks. There's no question about how much time and effort and work has gone into that. So thank you.

(Applause.)

UNIDENTIFIED: Can I ask a clarifying question? On January 1, 2016, what -- what is this group supposed to have decided or is this group dissolving, and there's a new group? I don't --

MS. AVERY: I'll go to the sentence before in the legislation. It says "The subcommittee shall also provide continuous review and commentary on policies and procedures relative to long-term care and the review of related projects. The subcommittee shall make

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recommendations to the Board no later than January 1, 2016, and every January after pursuant to the subcommittee's responsibility for the continuous review and commentary on policies and procedures relative to long-term care."

So at some point we also got to go back and look at rules, and if you guys say it's okay, we don't need any rule changes, that's what we can report. If you say we need to redo our application, which we did -- so we're pretty -- we're making some progress. It's just not right here in our face. If we need to make changes to the applications, if we need to change definitions, add services, which you all discussed today and agreed that we don't need to do that, or put other additional services related to long-term care under the purview of the Board, things of that nature. So it's widespread.

UNIDENTIFIED: And it formalizes where you are at that time. A report will be made. You may not have every recommendation that you have in the back of your head, but there are certain -- even from what Judy's report was, there's certain things that are consensus on.

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Those could be recommendations that go to the board. It may not be all the recommendations but --

MS. AVERY: And we probably should come up with some kind of working chart to show our progress.

MS. CREDILLE: Well, yeah, because we're meeting in August. So think about it. Back into this. We'll meet again in October. October's task --

This is Cece Credille, by the way.

October's task will be that we have to have a list because we won't meet in November and December. Right?

MS. AVERY: Okay. We'll keep that mind.

MS. CREDILLE: So if we sort of back into this, we will have two more meetings to have a list of recommendations -- or a report, I should say.

MS. AVERY: A report.

MS. CREDILLE: A report.

CHAIRMAN WAXMAN: A report, not a set of recommendations.

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Thank you, Cece.
The last thing I'd like to do, again, on behalf of the entire board, is to express our condolences to Alan on his recent loss. So, again --
MR. GAFFNER: Thank you, Mr. Chairman. That's very kind of you. Thank you.
CHAIRMAN WAXMAN: I hate to end on such a note but -- you going to help me get out of this?
MS. AVERY: No. We have one more.
CHAIRMAN WAXMAN: Okay.
MS. AMIANO: Mr. Chairman, I still have -- I need clarification. So does the group want us to move forward or not?
And I think to -- to John's point, these are just the group of associations who met and discussed it. It hasn't -- those nine points aren't necessarily what this committee believes. So if we're to move forward, I'd like, you know, kind of what are the two or three things -- no more than three -- to work on first.
MS. AVERY: Three things?
MS. AMIANO: No more than three.

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MS. AVERY: Can we -- can you charge us with looking at it and doing that? Making those --
MS. AMIANO: Okay. So do you need a motion? What do you need? No? Yes? No?
CHAIRMAN WAXMAN: No. It's just a charge to staff to do that. What else -- what else do you have on the --
MS. AVERY: Claire.
CHAIRMAN WAXMAN: What about Claire?
MS. BURMAN: The list of people and how they're represented.
MS. AVERY: Okay. According to the statute -- in the statute, we had to -- we agreed with HCCI that somewhere on our list that's posted on the website that it would identify who's representing who. That was one of the compromises. So we want to do that.
So I would ask, like, I know -- I forget what you (inaudible), Cece, but in some places we put the association that you're affiliated with.
MS. CREDILLE: I could give a rip. I'm here for Illinois Health Care. You don't

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have to put that in the minutes, but I'm here for Illinois Health Care.
MS. AVERY: That was not of ours. That was a compromise that we made with Donna so that we can see it at a glance and a snapshot because, again, it was confusing to us, confusing to her, and everybody else. So we just wanted to know if it was okay to put -- Judy, we made you HCCI.
MS. CREDILLE: No, don't put me HCCI.
(Discussion in Chicago amongst themselves.)
COURT REPORTER: I'm done. I'm done. I'm done.
MS. AVERY: Okay.
COURT REPORTER: I'm done.
MS. AVERY: Well, you can't stop yet because we're not done.
COURT REPORTER: We'll you're talking -- you're just talking back and forth and I did not get any of that; so I'm done.
MS. AVERY: Okay. We will clarify it. You don't have to have that in the record.
COURT REPORTER: Thank you.

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MS. AVERY: So I would ask Ann to look at the different people that's on here and ask how we want -- how you would like us to represent you because that was part of the agreement that we made as a result of 3510.
MS. GUILD: So am I supposed to go through the list?
MS. AVERY: Just the ones that we know. Judy.
MS. GUILD: Judy is LeadingAge. Cece, IHCA.
UNIDENTIFIED: See can't hear you.
MS. GUILD: Or sorry. Alan.
MR. GAFFNER: HCCI, Ann.
MS. GUILD: Pat.
MS. O'DEA EVANS: I'm with the Illinois Continuity of Care Association.
CHAIRMAN WAXMAN: I haven't heard that name in a long time.
MS. GUILD: Okay. Steve.
MR. LAVENDA: I'm neutral. I'm not representing any association.
MS. GUILD: Okay. Frank isn't here. Bill?

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MR. CASPER: LeadingAge.
MR. FLORINA: I'm with him. I'm neutral.
MS. GUILD: Okay.
CHAIRMAN WAXMAN: Tim, are you representing LeadingAge?
MR. PHILLIPPE: I believe so.
CHAIRMAN WAXMAN: Or are you neutral?
MR. PHILLIPPE: I don't think people would say I'm neutral.
MS. GUILD: Anybody know Carolyn?
UNIDENTIFIED: No. Just nothing. Long-term care industry.
MS. GUILD: Okay.
COURT REPORTER: Who -- what? what did Carolyn say?
UNIDENTIFIED: Nothing.
UNIDENTIFIED: She's not here.
UNIDENTIFIED: Neutral. Neutral.
MS. GUILD: Okay. Who else don't I have?
MR. FOLEY: Consumer.
MS. GUILD: No. Neutral?
MR. FOLEY: Independent. Whatever

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you want to call it.
COURT REPORTER: I don't know who's talking again.
MR. FOLEY: Charles Foley.
COURT REPORTER: Are you neutral?
MR. FOLEY: Yes. I am neutral.
COURT REPORTER: Thank you.
MS. AVERY: All right. That's it.
CHAIRMAN WAXMAN: Need a motion to adjourn.
UNIDENTIFIED: How do you have Bill Bell?
MS. GUILD: You know what? I must have an old list.
MS. AVERY: Yeah. We have Bill on the new list as --
MS. GUILD: Yeah. Yeah.
MS. AVERY: We do.
CHAIRMAN WAXMAN: Can I have a motion to adjourn?
MR. FOLEY: So moved.
CHAIRMAN WAXMAN: Second.
UNIDENTIFIED: Second.
CHAIRMAN WAXMAN: Have a motion.

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Have a second.
All in favor?
(Ayes heard.)
CHAIRMAN WAXMAN: Anyone opposed?
(No response.)
CHAIRMAN WAXMAN: Motion is approved. Thank you all.
(Adjourned at 1:30 P.M.)

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